The Cost Containment Literature: Index and Summary

Appendix D

Ontario

APPENDIX D

THE COST CONTAINMENT LITERATURE:

INDEX AND SUMMARY

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For the Select Committee on
Health Care Financing and
Costs

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PREFACE

This index and summary of the cost containment literature has been prepared for the Select Committee of the Legislature on Health Care Financing and Costs. The Committee's terms of reference require a review of "existing reports which relate to methods and means of containing or reducing health care costs". A list of these reports was prepared by the Ministry of Health for the Standing Committee on Social Development in April of 1978. This list formed the base and was supplemented with additional material relating to particular issues raised by the Select Committee.

In all, the list comprises forty-five documents that are assigned consecutive numbers for reference purposes. The documents are divided into three broad categories: first, those that deal mainly with cost containment, numbered 1 to 19 inclusive; second, those with substantial cost containment implications, and which are numbered 20 to 36 inclusive; and third, those that deal with issues related to cost containment, numbered 37 to 45 inclusive. Within the categories, the listing is not in order of priority.

A list of ten major cost containment issues were identified:

1. Regionalization;
2. Appropriate utilization of resources;
3. Limitation on resources;
4. Increasing awareness of cost;
5. Reduction in insured benefits;
6. Health promotion and illness prevention;
7. Alternative methods of delivering health care;
8. Incentives to providers;
9. Alternative methods of remunerating providers; and
10. Improvement in the information system.

Again, the list is not in order of priority; five of the headings were further subdivided.

In order to assist the reader in locating the reports which make recommendations relating to each of the issues, two indices were constructed: the first, entitled "Index to Major Issues", lists the issues and identifies the reports that deal with them; the second, entitled "Annotated Index to Major Issues", expands the first index by giving, in capsule form, the content of the recommendations made.

Finally, the reports are summarized in two forms: firstly, in a section entitled "Highlights of Reports", they are listed in order and the recommendations listed in capsule form; and secondly, in a section entitled "Synopses of Reports", the reports are listed in order, the recommendations stated and a brief synopsis of the rationale for the recommendations given.

List of Reports and Articles Analyzed and Summarized

1. Report of the Joint Advisory Committee of the Government of Ontario and the Ontario Medical Association on Methods to Control Health-Care Costs (Taylor Report) Ontario. 1977

combined with

2. An Integration of the Comments of Management Committee and Ministry Staff on "The Report of the Joint Advisory Committee of the Government of Ontario and the Ontario Medical Association on Methods to Control Health-Care Costs"., Ontario: Ministry of Health. March 31, 1978

3. Bennett, J.E., and Krasney, J., Health Care in Health Series. Toronto: The Financial Post. March 26 - May 7, 1977.

4. Issues and Alternatives. 1976. Ontario: Ontario Economic Council. 1976.

5. The Report of the Special Program Review. (The Henderson Report). Ontario. 1975.

6. Report of the Minister of Health's Committee to Examine The Effects of Fiscal Constraints on Hospital Employees. (Deutsch Report) Ontario: Ontario Ministry of Health. 1974.

7. A Review of the Ontario Health Insurance Plan. Ontario: Ontario Council of Health. 1973.

combined with

8. A Review of the Ontario Health Insurance Plan. Ontario Council of Health. 1973. Ministry of Health Analysis. Ontario: Ontario Ministry of Health. March 1975.

9. Review of the Ontario Parcost Program. Ontario: Ontario Council of Health. 1973.

10. Report of the Task Force on OHIP Cost Controls. Vol. I. Physician and Laboratory Services. Ontario: Ontario Ministry of Health. 1973.

11. Report of the Task Force on OHIP Cost Controls. Vol. II. Payment to Chiropractors, Osteopaths, Chiropodists, Optometrists and Dentists. Ontario: Treatment and Rehabilitation Division. Ontario Ministry of Health. 1973.

12. Report of the Task Force on OHIP Cost Controls. Vol. III. Clinical Education System and Radiology/Pathology Hospital Services. Ontario: Treatment and Rehabilitation Division. Ontario Ministry of Health. 1973.

13. Report of the Laboratory Studies Committee. Ontario: Ontario Ministry of Health. 1976.

14. Control of Private Laboratory Costs Through Tendering. Ontario: Ontario Ministry of Health. 1976.

15. Hamilton District Program in Laboratory Medicine. A Report from Woods, Gordon & Co. Ontario: Ontario Ministry of Health. 1976.

16. Report of the Committee on Health-Care Costs Ontario: Ontario Department of Health. 1971.

17. Task Force Reports on the Cost of Health Services in Canada. Vol. I - III. (Summary). Ottawa: Department of National Health and Welfare. 1969.

18. The Ontario Committee on Taxation Report (Smith Report) Vol. I - III. Ontario: Government of Ontario. 1967.

19. Taxation in Ontario: A Program For Reform: The Report of the Select Committee of the Legislature on the Ontario Committee on Taxation. (White Report). Ontario: Government of Ontario. 1969.

20. Evans, R.G. and Williamson, M.F. Extending Canadian Health Insurance: Options for Pharmacare and Denticare. Ontario: Ontario Economic Council. Research Studies. 1978.

21. Let Us Take Care. A Report to the People of Ontario. Ontario: Ontario Nurses Association, 1977.

22. Ontario Public Health: Some Current Issues. 1977. Ontario: Ontario Ministry of Health. 1977

23. Report, Reaction, Response - The Health-Care System in Ontario. Ontario: Ontario Ministry of Health. 1975

24. Report of the Health Planning Task Force. (Mustard Report). Ontario: Ontario Ministry of Health. 1974.

25. Spitzer, W.O., Roberts, R.S. and Delmore, Terry, "Nurse Practitioners in Primary Care: Assessment of Their Deployment with the Utilization and Financial Index". Canadian Medical Association Journal. Vol. 114 (June 19, 1976) 1103 - 1108.

26 The Nurse Practitioner in Primary Care. Ontario: Ontario Council of Health. 1975

27. Postgraduate Manpower Committee Report. (Boone Report). Council of Ontario Faculties on Medicine. Ontario: Ontario Ministry of Health. 1975.

28. Report of the Special Study Regarding the Medical Profession in Ontario. (Pickering Report). Ontario: Ontario Medical Association. 1973.

29. A Study of the Implications of Using a Plastic Identity Card For the Health Insurance Plan. Ontario: Management Consulting Division of Government Services. 1974.

30. A Study of the Implications of Using a Personal Identifier in the Ministry of Health. Ontario: Management Consulting Division of Government Services, 1974

31. Report on the Evaluation of Chronic Home Care Ontario: Ontario Ministry of Health. 1977.

32. Science For Health Services. Report No. 22. Science Council of Canada. 1974

33. Health Care in Canada: A Commentary. Background Study for the Science Council of Canada (R. Robertson Report). Special Study. No. 29. Science Council of Canada. 1973.

34. Regional Organization of Health Services. Report of the Ontario Council of Health. 1970.

35. A New Perspective on the Health of Canadians (Lalonde Report) Ottawa: Government of Canada: Department of National Health and Welfare. 1974

36. Report of the Task Force on District Health Councils. Ontario Council of Health. 1975.

37. Health Research Requirements. Task Force Report. Ontario: Ontario Ministry of Health.

38. Report of the Provincial - Municipal Grants Reform Committee. Vol. I. Ontario. 1977.

39. Mental Health Services Personnel. Ontario: Ontario Council of Health. 1973

40. The Planning Function of District Health Councils. Ontario Council of Health. 1977

(note:The Report of the Task Force on the Planning Function of District Health Councils and the Development of a Data Base for District Health Councils are source documents for this report).

41. Evaluation of Primary Care Services (Spitzer Report) A Report of the Ontario Council of Health. Ontario: Ontario Council of Health. 1976

42. Report of the Royal Commission on Metropolitan Toronto (Robarts Report) Vol. 1 - 2. Province of Ontario (TEIGA) 1977

43. Health Research Priorities For Ontario. A Report of the Ontario Council of Health. 1977.

44. An Estimate of the Economic Burden of Ill-Health. A Study For the Ontario Council of Health. 1976

45. The Economics of Health Research. Ontario Council of Health. 1973

Index to Major Issues

Issue	Location (Report/Article)	Report No.
1. Regionalization	Taylor Report 1977	1
	Ontario Committee on Health-Care Costs 1971	16
	Henderson Report 1975	5
	Health Services in Canada 1969	17
	Financial Post Series 1977	3
	Issues and Alternatives 1976	4
	Deutsch Report 1974	6
	Laboratory Studies Committee 1976	13
	Smith Report 1967	18
	Let Us Take Care 1977	21
	Mustard Report 1974	24
	Response, Reaction 1975	23
	Lalonde Report 1974	35
	District Health Councils 1975	36
2. Appropriate Utilization of Resources.		
(1) Manpower (includes manpower substitution and expansion of role of specific practitioners e.g. nurses, optometrists etc.)	Committee on Health-Care Costs 1971	16
	Henderson Report 1975	5
	Health Services in Canada 1969	17
	Financial Post Series 1977	3
	Issues and Alternatives 1976	4
	Review of OHIP 1973	7
	Vol. II - OHIP Cost Control 1973	11
	Let Us Take Care 1977	21
	Mustard Report 1974	24
	Lalonde Report 1974	35
	Science for Health Services 1974	32
	Pickering Report 1973	28
2. (2) Services (includes elimination of unnecessary utilization and/or duplication of services; reducing the use of more costly facilities or services such as emergency departments or hospitalization for services available on ambulatory basis and centralization of services.)	Taylor Report 1977	1
	Health-Care Costs 1971	16
	Health Services in Canada 1969	17
	Henderson Report 1975	5
	Issues and Alternatives 1976	4
	Review of OHIP 1973	7
	Deutsch Report 1974	6
	Vol. II - OHIP Cost Controls	11
	Hamilton District Prog. 1976	15
	Laboratory Costs-Tendering 1976	14
	Laboratory Studies 1976	13
	Let Us Take Care 1977	21
	Mustard Report 1974	24
	Lalonde Report 1974	35
	Pickering Report 1974	28

Issue	Location (Report/Article)	Report No.
3. Limitations on Resources		
(1) Manpower - medical and non-medical resources	Taylor Report 1977	1
	Henderson Report 1975	5
	Financial Post Series 1977	3
	Mustard Report 1974	24
	Boone Report 1975	27
(2) Facilities - including co-ordination of specialized services, restrictions on hospital construction, specialized programs and diagnostic services. (Co-ordination of specialized services relatively easy to effect and has been most successful.)	Henderson Report 1975	5
	Health Services in Canada 1969	17
	Financial Post Series 1977	3
	Issues and Alternatives 1976	4
	OHIP Cost Controls - Laboratory Services 1973	10
	Review of OHIP 1973	7
4. Increasing Awareness of Cost		
(1) Provider - physicians and other personnel.	Taylor Report 1977	1
	Health-Care Costs 1971	16
	Health Services in Canada 1969	17
	Lab. Studies 1976	13
(2) Consumer - user charges, itemized accounts of services rendered; premiums etc.	Taylor Report 1977	1
	Henderson Report 1975	5
	Issues and Alternatives 1976	4
	Review of OHIP 1973	7
	Smith Report 1967	18
	White Report 1969.	19
	Pickering Report 1973	28
5. Reduction in Insured Benefits and non-expansion of Benefits. - elimination of items from Plan and constraining any expansion of insured services.	Taylor Report 1977	1
	Health-Care Costs 1971	16
	Review of OHIP 1973	7
	OHIP Cost Controls - Vol. I. 1973	10
	OHIP Cost Controls - Vol. II. 1973	11
	Evans and Williamson. 1978	20

Issue	Location (Report/Article)	Report No.
6. Health Promotion and Illness Prevention - includes role of education, measures to change life-styles, environments, and legislation to reduce accidents/illness.	Health-Care Costs 1971	16
	Health Services in Canada 1969	17
	Financial Post Series 1977	3
	Issues and Alternatives 1976	4
	OHIP Cost Controls Vol. II.	11
	Let Us Take Care 1977	21
	Ontario Public Health. 1977	22
	Science for Health Services 1974	32
7. Alternatives in Delivery Care System		
(1) Primary Care Services - changes in modes of delivery such as group practices, home visits, greater accessibility of ambulatory services, establishment of community health centres.	Health Care Costs 1971	16
	Financial Post Series 1977	3
	Issues and Alternatives 1976	4
	Let Us Take Care 1977	21
	Public Health 1977	22
	Mustard Report 1974	24
	Pickering Report 1973	28
(2) Secondary and tertiary services, includes shifts from acute-care treatment hospitals to community-based programs such as home care and chronic care facilities e.g. nursing homes.	Taylor Report 1977	1
	Health Care Costs 1971	16
	Henderson Report 1975	5
	Health Services in Canada 1969	17
	Financial Post Series 1977	3
	Issues and Alternatives 1976	4
	Review of OHIP 1973	7
	Deutsch Report 1974	6
	Let Us Take Care 1977	21
	Public Health 1977	22
	Lalonde Report 1974	35
	Pickering Report 1973	28
8. Incentives to Providers. (financial incentives to practitioners and institutions to provide appropriate and adequate care for least cost).	Taylor Report 1977	1
	Health Care Costs 1971	16
	Health Services in Canada 1969	17
	Financial Post Series 1977	3
	Issues and Alternatives 1976	4
	Deutsch Report 1974	6
	OHIP Cost Controls Vol. III 1973	12
	Lalonde Report 1974	35

Issue	Location (Report/Article)	Report No.
9. Changes in Remuneration		
(1) Facilities: hospitals, laboratories, other institutions (includes use of global budgets, and elimination of fee-for-service system to laboratories).	Health Services in Canada 1969	17
	Issues and Alternatives 1976	4
	Review of OHIP 1973	7
	Deutsch Report 1974	6
	OHIP Cost Controls Vol. I (b)	10
	OHIP Cost Controls Vol. III	12
	Laboratory Studies 1976	13
	Mustard Report 1974	24
(2) Practitioners (includes alternatives to fee-for-service system and the possibility of global budget for medical services)	Health Care Costs 1971	16
	Health Services in Canada 1969	17
	Financial Post Series 1977	3
	Issues and Alternatives 1976	4
	OHIP Review 1973	7
	OHIP Cost Controls Vol. I 1973	10
	OHIP Cost Controls Vol. II + III	11,12
	Mustard Report 1974	24
	Pickering Report 1973	28
10. Improvements in Information System/Data Base. (Planning and management of health-care system, including cost containment and cost control, requires an adequate data base and information system. Major deficits exist in this area)	Health Care Costs, 1971	16
	Health Services in Canada 1969	17
	Issues and Alternatives 1976	4
	OHIP Cost Controls. Vol. I	10
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	Let Us Take Care 1977	21
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2/2. Appropriate Utilization of Resources: Services including Elimination or Reduction in Unnecessary Utilization and Centralization of Services

3/1. Limitations on Resources: Manpower

3/2. Limitations on Resources: Facilities, including Co-ordination of Specialized Services

4/1. Increasing Awareness of Cost: Provider

4/2. Increasing Awareness of Cost: User

5. Reduction in Insured Benefits and Non-Extension of Insured Benefits

6. Health Promotion

7/1. Alternatives in Delivering Care System: Primary Care

7/2. Alternatives in Delivering Care System: Secondary and Tertiary Care

8. Incentives to Providers

9/1. Changes in Remuneration: Facilities

9/2. Changes in Remuneration: Practitioners

10. Improvements in Information System Data Base

1. Issue: Regionalization

Location:

1. Taylor Report (Pilot project - DHC - providers with fiscal responsibility).

2. Ontario Committee on Health-Care Costs 1971 (Regional arrangements for bulk purchasing by hospitals).

3. Henderson Report, 1975. (block funding be extended to a locally elected body for all aspects of health expenditure, excluding medical services).

4. Task Force Report on Health Services in Canada, 1969. (regional boards with advisory capacity to Provincial Governments - assessment of needs, plan and development of regionalized, comprehensive and integrated health-care system, improve communication between agencies. Responsible for recommending new and expanded facilities, closure of facilities or conversion to alternate use).

5. Financial Post Series, 1977 (decentralize rationalization and deployment decisions).

6. Issues and Alternatives O.E.C., 1976 (gradual implementation of regionalization concepts. Recommendations of D.H.C. be made known to the public).

7. Deutsch Report, 1974 (planning for new programs or facilities on a regional basis).

8. Report of the Laboratory Studies Committee, 1976 (planning and co-ordination of laboratory services on a district, planning area and Provincial basis).

9. Smith Report (regional government to facilitate more economical and effective public health units and hospital facilities).

10. Let Us Take Care, 1977 (formation, composition and functions of district health councils).

11. Mustard Report, 1974 (establishment of regional and district health councils).

12. Lalonde Report, 1974 (development of regional bodies with comprehensive authority).

13. Report of the Task Force on District Health Councils 1975 (encouragement of district health councils).

2/1 Issue: <u>Appropriate Utilization of Resources: Manpower includes Manpower Substitutions.</u>

<u>Location:</u>

1. Ontario - Report of the Committee on Health-Care Costs (elimination of duties in nursing service, use of work-study technique in hospitals, contract out of dietary, housekeeping services, measures to increase productivity of workers, manpower substitution: Physician-nurse practitioners and other allied medical personnel; nurses - nursing assistant and aides).

2. Henderson Report, 1975 (reduction in paid hours of hospital staff).

3. Task Force Report - Health Services in Canada, 1969 (Use work-study programs in hospitals and improvement in management of nursing resources; medical care plans should cover the services of allied health professionals working under the direction of practicing physicians, training programs for practitioner-associates).

4. Financial Post Series, 1977 (Limit total wage bill of health care workers).

5. Issues and Alternatives, O.E.C., 1976 (reduction of constraints to effective manpower substitution; substitution of capital for health manpower).

6. Review of OHIP, 1973 (inclusion in medical practice of nurse practitioners and other ancillary personnel; immunization procedures to be carried out by nurses; justification for assistant fees).

7. Vol. II. Task Force on OHIP Costs (establish means of involving optometrists in organized settings and expanding their role; inclusion of chiropractors, chiropodists and osteopaths in health team).

8. Let Us Take Care, 1977 (Use of nurse practitioners, expansion of role of public health nurse).

9. Mustard Report, 1974 (Use of nurse practitioners and other allied health professionals).

10. Lalonde Report, 1974 (extension of role of nurse practitioners)

11. Science For Health Services, 1974 (redefinition of roles).

12. R. Robertson Report, (Changes in roles of practitioners).

13. Pickering Report, 1973 (expansion of role of paramedical personnel).

2/2 Issue: <u>Appropriate Utilization of Resources: Services including Elimination or Reduction in Unnecessary Utilization and Centralization of Services.</u>

<u>Location:</u>

1. Taylor Report (development of standards for disease management).

2. Ontario Committee on Health Care Costs, 1971 (develop criteria for use of diagnostic and investigative services; assess need for demand for such services; control admissions, discharge and utilization of hospital services; eliminate duplication of diagnostic and investigative services; guidelines for prescription drugs; physician who over-use or abuse the system should receive lower rate for services; development of physician and patient profiles).

3. Task Force Reports - Health Services in Canada, 1969. (Standards for admission, discharge and utilization, diagnostic and investigative services; review of patterns of physician practices; judicious use of mass screening procedures).

4. Henderson Report, 1975 (ensure that existing hospital facilities are being used fully and appropriately; phasing-out of surplus beds and expensive equipment facilities, control volume of laboratory services)

5. Issues and Alternatives. O.E.C. 1976 (closure of small inefficient hospital facilities or conversion to community health centre, nursing home)

6. Review of OHIP, 1973 (criteria for use of hospital facilities; pre-admission investigations and resulting information be condition of admission; measure to eliminate use of out-patient department as second office; guideline criteria for diagnostic and investigative procedures; development of physician profiles with respect to diagnostic services, identification of unusual situations related to volume and quality of services)

7. Deutsch Report, 1974 (attention to use of expensive hospital facilities and procedures when adequate care and appropriate care can be provided elsewhere; unnecessary and excessive use of procedures and expensive specialities and unnecessary proliferation of expensive specialist services).

8. Vol. II. Task Force Report on OHIP Cost Control (eliminate requirement of hospitalization as pre-requisite for payment of 23 insured dental services).

9. Hamilton District Program in Laboratory Medicine. 1976. (no conclusive finding with respect to cost effectiveness of commercial versus hospital laboratory services).

2/2

10. Control of Private Laboratory Costs Through Tendering, 1976 (tendering not a valid solution at present time).

11. Report of the Laboratory Studies Committee, 1976. (re-education of physicians regarding use of laboratory services, standardized requisition forms, monitoring of physician use of laboratory services).

12. Let Us Take Care, 1977 (committees be established to control misuse of hospital facilities).

13. Mustard Report, 1974 (rationalization of secondary care and development and strengthening of primary care).

14. Lalonde Report 1974 (means to ensure that physicians will make a more objective and effective use of drugs).

15. Pickering Report (revision in code of Billing Ethics).

Centralization of Services

Location

1. Ontario Committee on Health Care Costs, 1971 (unification of all communicable disease activities of the Provincial level under one program need to prevent duplication of services).

2. Task Force Reports - Health Services in Canada, 1969. (group purchasing and use of centralized services such as laundries by hospitals).

3. Deutsch Report, 1974 (centralization of hospital services to reduce costly and unnecessary duplication).

4. Let Us Take Care 1977 (central registries for assessment and placement services).

5. Report on Laboratory Studies, 1976 (centralized committees at regional, planning and Provincial levels to co-ordinate and plan laboratory services use).

3/1 Issue: <u>Limitations on Resources: Manpower</u>

<u>Location:</u>

1. Taylor Report, 1977 (medical school enrollment compatible with physician/patient ratio target).

2. Henderson Report, 1975. (government to control number, type and geographical distribution of physicians; medical school enrollment to remain at present level, and training programs to maintain adequate supply of general practitioners, maintain physician/population ratio of 1.585).

3. Financial Post Series 1977 (limit growth of physician/population ratio).

4. Mustard Report, 1974 (limit numbers of physicians practicing in a district or region).

5. Boone Report 1975 (setting average output quota for medical training programs).

3/2 Issue: Limitations on Resources: Facilities including co-ordination of Specialized Services.

Location:

1. Henderson Report, 1975 (restrictions on expansion of hospital facilities).

2. Task Force Report - Health Services in Canada, 1969 (limit expansion of acute care hospital facilities and specialized services).

3. Financial Post Series, 1977 (moratorium on hospital construction, limits on specialized programs and diagnostic resources).

4. Issues and Alternatives, O.E.C. 1976 (Reductions in acute care facilities to occur simultaneously with development of alternatives).

5. Task Force on OHIP Costs: Laboratory Services (limit expansion of commercial laboratories).

Co-ordination of Specialized Services.

Location:

1. Henderson Report, 1975 (hospitals in urban areas be required to specialize in selected medical and surgical procedures).

2. Task Force - Health Services in Canada. 1969 (restrictions on number and location of specialized services).

3. Review of OHIP, 1973 (specialized services in particular hospitals, development of specialized services follow established guidelines; limited number of hospitals be designated for afterhours or weekend emergencies).

4/1 Issue: <u>Increasing Awareness of Cost: Provider</u>

<u>Location:</u>

1. Taylor Report, 1977 (greater involvement of medical staff in hospital administration).

2. Ontario Committee on Health Care Cost, 1971 (increase hospital employees and physician awareness of costs of services, particularly diagnostic and investigation).

3. Health Services in Canada, 1969 (education of providers include training in economics of health care).

4. Report of the Laboratory Studies Committee, 1976 (provide physicians with information concerning volume and costs of generated lab. services together with comparison with local peers; education and re-education of physicians with respect to costs of lab. services).

4/2 Issue: <u>Increasing Awareness of Cost: User</u>

<u>Location:</u>

1. Taylor Report, 1977 (User premiums equaling 1/3 of insurance costs, cost statement of medical services issued to each patient).

2. Henderson Report, 1975 (alternative proposals for financial and other ways to increase public awareness of costs e.g. tax rebates, user charges; increases in hospital charges for private and semi-private accommodations).

3. Issues and Alternatives, O.E.C. 1976 (cost-sharing by patients related to use of health care services).

4. Review of OHIP, 1973 (mechanism for patient verification of services and costs of services rendered). Premiums account for 1/3 entire cost of OHIP).

5. Smith Report, 1969 (Premium system, use of receipted hospital invoice showing costs of services rendered).

6. White Report (premium system maintained).

7. Pickering Report, 1973 (Inform patient of OHIP billings).

5. Issue: Reduction in Insured Benefits and Non-Extension of Insured Benefits.

Location:

1. Taylor Report (elimination of specific non-prescription drugs).

2. Ontario Committee on Health Care Costs, 1971 (Non-insurance for luxury or unnecessary medical services, experimental and unproven mass procedures).

3. Review of OHIP, 1973 (Recommendations #12, 19, 21, 26-33 all deal with specific activities).

4. Task Force on OHIP Cost Controls. Vol I. Physician Services. (Elimination of specific benefits and limitations on others if Provincial schedule of benefits introduced).

5. Vol. II Task Force on OHIP Cost Controls (eliminate radiological services provided by Chiropractors, Chiropodists and Osteopaths; eliminate payments to dentists for surgical removal of teeth, erupted, unerupted or impacted).

6. Evans and Williamson 1978 (costs of pharmacare and denticare programs would outweigh benefits).

6. Issue: Health Promotion

Location:

1. Ontario Committee on Health Care Costs, 1971 (implementation of effective immunization program).

2. Task Force Reports on the Cost of Health Services in Canada 1969. (development of communicable disease control programs; standardized immunization procedures).

3. Financial Post Series, 1977 (Upgrade health education in schools, suturation training in first aid, institute measures to reduce car accident injuries and death).

4. Issues and Alternatives. O.E.C. 1976 (incentives or disincentives to encourage or discourage consumer behaviour vis-a-vis prevention through cost-sharing; governments actions with respect to accident prevention).

5. Vol. II. Task Force on OHIP Cost Controls (dental plan for children).

6. Let Us Take Care. 1977 (public education programs).

7. Ontario Public Health, 1977 (emphasis on prevention and expansion of educational activities).

8. Science for Health Services. 1974 (enhance protection of health).

7/1 Issue: Alternatives in Delivering Care System: Primary Care

Location:

1. Ontario Committee on Health Care Costs, 1971 (retain fee-for-service but studies need to be made of alternative modes of practice such as group practices and multi-discipline practices).

2. Financial Post Series, 1977. (global medical practices).

3. Issues and Alternatives, O.E.C. 1976. (Group practice).

4. Let Us Take Care, 1977 (Establishment of community health centres).

5. Ontario Public Health 1977 (expansion of experiments in alternative methods of providing primary care).

6. Mustard Report 1974 (group practices, team approach).

7. Pickering Report 1973 (re-assessment of medicine's responsibility to the health care delivery system).

7/2 Issue: <u>Alternatives in Delivery Care System: Secondary and Tertiary Care.</u>

<u>Location:</u>

1. Taylor (Review of discharge data, list of surgical procedures to be performed on out-patient or day surgery basis, appropriate use of emergency departments, system of placement services).

2. Ontario Committee on Health Care Costs, 1971 (home care should be part of a continuum of health care services and financed in an appropriate manner; patient on home care should not pay for services that would be available on insured basis if institutionalized).

3. Henderson Report, 1975 (develop and assess alternatives to public hospital system which can be operated at lower cost and ease need for hospital facilities).

4. Task Force Report - Health Services in Canada, 1969 (development of patient care classification system; increased use of ambulatory services, home care programs; reimbursement rate for physician services rendered in out-patient hospital facility be less than if provided in physician's office).

5. Financial Post Series, 1977. (Direct resources to high quality, lower costs forms of care).

6. Issues and Alternatives. O.E.C. 1976 (development of alternatives to substitute for acute care facilities).

7. Review of OHIP, 1973 (development of alternatives to acute care facilities).

8. Deutsch Report, 1974 (achieve a balance of health-care facilities so that appropriate and less expensive facilities are available).

9. Let Us Take Care 1977 (expansion of home care services, development of alternatives to acute care hospitals).

10. Ontario Public Health, 1977 (expansion of home care programs).

11. Lalond Report 1974 (support for home care and other community-based services).

12. Pickering Report 1973. (Alteration in modes of delivery).

8. Issue: Incentives to Providers

Location:

1. Taylor Report, 1977 (incentives to hospitals).

2. Ontario Committee on Health Care Costs, 1971 (incentive system to hospitals: share in savings).

3. Health Services in Canada, 1969 (incentives be provided to hospitals to reduce costs; expenditures on patient care, medical services, education and research need to be delineated by hospitals).

4. Financial Post Series, 1977 (revise hospital budgeting systems to provide incentives for use of less costly forms of treatment).

5. Issues and Alternatives O.E.C. 1976. (Financial incentives to hospitals and physicians).

6. Deutsch Report, 1974 (provide incentives to hospitals and physicians to encourage use of less expensive procedures, facilities or services).

7. Vol. III. Task Force on OHIP Cost Controls 1973 (negotiate contracts which provide incentives to radiology/pathology not to increase volume of services).

8. Lalonde Report 1974 (incentives for providing satisfactory care of the lowest cost).

9/1 Issue: Changes in Remuneration: Facilities

Location:

1. Health Services in Canada, 1969 (fee-for-service renumeration for laboratory and radiology services require delineation of overhead, professional component and capital investment costs).

2. Issues and Alternatives O.E.C. 1976 (review of each major hospital's operation: negotiated fixed cost per case, adjusted for diagnosis, security, length of stay).

3. Review of OHIP, 1973 (payment to physicians for services and technical component of diagnostic services be provided in hospital global budget; payment of private radiology clinics and laboratories on a budget basis).

4. Deutsch Report, 1974 (global budgets for hospitals, monitoring line by line every 3 - 4 years).

5. Task Force on OHIP Cost Control Vol. I. 1973 (global budgets for laboratory services; a Provincial schedule of benefits rather than profession's schedule of fees. Controls required on both price and utilization).

6. Vol. III. Task Force on OHIP Cost Control 1973 (establish separate cost centres for hospital labs., develop a global budget for commercial laboratories' services based on a formula payment, develop a relative valve fee schedule for laboratory services).

7. Report of the Laboratory Studies Committee 1975. Ontario Ministry of Health 1976 (development of equitable funding mechanism for all laboratory services).

8. Mustard Report 1974 (revisions in payment benefits to Pathologists and Radiologists, revised method of payment for capital and operating cost of laboratories).

9/2 Issue: <u>Changes in Remuneration: Practitioners</u>

<u>Location:</u>

1. Ontario Committee on Health-Care Costs, 1971 (retain fee-for-service).

2. Health Services in Canada, 1969 (physician services rendered in out-patient facilities be reimbursed at lower rate than office - based services. Experiments should be made with capitation method).

3. Financial Post Series, 1977 (Pilot test alternatives to fee-for-service system).

4. Issues and Alternatives, O.E.C. 1976 (Alternatives to fee-for-service system, likely capitation fees or salary system).

5. Ontario Health Insurance Plan, 1973 (payment for primary care services be at general practitioner rate. Specialist rates require a referral).

6. Review of OHIP, 1973 (sliding scale for physician services rendered to hospitalized patient).

7. Task Force on OHIP Cost Controls-Physicians Vol. I, 1973 (development and use of a Provincial schedule of benefits rather than the profession's schedule of fees; establish a global budget for each fiscal year - a fixed pool of funds allocated to fee-for-service physicians).

8. Vol. II of Task Force on OHIP Cost Controls: Chiropractors, Osteopaths, Chiropodists, Optometrists and Dentists (establish maximum payment per contract for Chiropractic or Chiropody services).

9. Vol. III of Task Force on OHIP Cost Controls. Clinical Education Radiology/Pathology (changes in payment system to clinical teachers; dissolve all existing contracts between hospitals and physicians which are inconsistent with plan payment policy).

10. Mustard Report 1974 (use of unit billing; elimination of differential in payment based solely on differences in educational qualifications, primary care services at primary care rate ; possibility of placing hospital-based physicians on salary).

11. Pickering Report 1973 (revision of fee-for-service system).

10. Issue: <u>Improvements in Information System Data Base</u>

<u>Location:</u>

1. Ontario Committee on Health-Care Costs 1971. (Effective evaluation or cost of programs limited by inadequate data base. Need to improve statistical data base).

2. Taylor Report 1977 (review of Provincial administration and audit procedures to identify and eliminate unnecessary paper work).

3. Health Services in Canada, 1969. (Information required for determining the fiscal effects of revisions in fee-for-service schedules on the earnings of a particular type of physician).

4. Issues and Alternatives, O.E.C. (Additional data required to determine effective means of modifying life style behaviours).

5. Task Force - OHIP Cost Controls: Laboratory Services, 1973 (need for careful analysis of the respective merits of commercial of practice associated and of hospital laboratories, and of public health laboratory network in order to define their respective roles).

6. Report of the Laboratory Studies Committee 1976 (development of a comprehensive laboratory service information system; evaluation of effectiveness and efficiency of laboratory services in public hospitals, public health and private sector).

7. Implications for Use of Personal Identifier 1974 (adoption of unique personal identifier means of monitoring health-care delivery system).

8. Let Us Take Care 1977 (studies into manpower and productivity of nursing services in hospitals).

9. Science for Health Services, 1974. (Research priorities - determination of effectiveness of approaches to health protection).

10. Pickering Report 1974 (establishing a medical Manpower Data Unit).

HIGHLIGHTS OF REPORTS

1. Report of the Joint Advisory Committee of the Government of Ontario and the Ontario Medical Association on Methods to Control Health Care Costs (Taylor Committee Report) Ontario. 1977.

Recommendations for cost-containment and financing focused on;

(1) User premiums;

(2) Non-extension or reduction of insured benefits;

(3) Increasing user awareness of costs;

(4) Limitations on physician resources;

(5) Development of standards for disease management;

(6) Incentives to hospitals;

(7) Appropriate use of hospital and other resources;

(8) District Health Council - provider membership - fiscal responsibilities other than reimbursement of physicians;

(9) Reduction in paper work (data base?).

Report #2 No short synopsis as this report dealt with responses to specific reports.

3. Health Care in Canada: A Series on the Nation's Health. J. E. Bennett and J. Krasny. The Financial Post. March 26 - May 7, 1977.

Health providers and the public need to know that resources for health services are limited. The government must establish and communicate specific limits. Three basic strategies for dealing with the current health care delivery system are:

(1) Ration resources; (2) slim the existing hospital structure and (3) establish incentives for providers to use the system wisely. In addition, a major effort must be placed behind a limited number of high-impact health promotion measures.

4. Issues and Alternatives. Ontario Economic Council 1976.

Two solutions proposed with respect to the problems of inefficient production of medical and hospital services are: (1) consolidation and (2) substitution. The Council believes that consolidation of small independent providers into group practice would allow for the implementation of a number of reforms that would take longer and be more difficult to implement independently. Inefficient hospitals exist and should be closed. Alternative care facilities need to be developed simultaneously with reductions in acute care hospital facilities. Manpower substitution would lead to more appropriate utilization of resources. Incentives need to be provided to the providers of care and the consumers of care. Some method of cost-sharing by patients should be borne by patients. More information is required to determine optimal and type of prevention activity required.

5. Report of the Special Program Review (Henderson Report).
Chapter 8. Ontario 1975

The key to cost control was identified as adjustment in attitudes toward individual behaviour and environmental factors in preserving and maintaining health. Recommendations were directed toward:

(1) increasing public awareness of health costs and discouraging careless or unnecessary use of health services. Investigate alternatives such as user fees and tax rebates.
(2) more productive utilization of acute care hospital facilities.
(3) increases in user charges for private and semi-private hospital facilities.
(4) more productive use of manpower resources in hospitals.
(5) development of alternatives, modes of care, such as Home Care.
(6) control on the number, type and geographical distribution of practicing physicians.
(7) block funding to local bodies for all aspects of health expenditure, excluding medical services.
(8) control volume of laboratory service.

6. The Effect of Fiscal Constraints on Hospital Employees.
(Deutsch Report) Ontario Ministry of Health. 1974

The fixed percentage units on increases in global budgets, the more severe global budget constraints and supplementary measures, such as reductions in bed numbers and freezes, have had little success in coping with the basic cost problems of hospitals. The measures have had a distorting and uneven impact on hospital employees. Recommendations: (1) retain fixed global budgets, but with modifications which would allow for increases in rates of salaries, wages etc., of all hospital employees, and planning on a regional basis. (2) review of global budgets of every hospital on a line-by-line and cost-centre basis every 3 - 4 years. (3) provision of incentives, centralization of services and balance of health-care services.

7. <u>A Review of the Ontario Health Insurance Plan.</u> Ontario Council of Health. 1973.

Purpose: To conduct a critical and objective review of the health insurance program as it related to physician services, especially with respect to the scope of benefits and schedule of fees as benefit payments. Recommendations deal with (1) mechanisms to control abuse of health professionals and consumers; (2) reductions in acute care facilities as adequate alternatives are developed; (3) medical manpower substitution; (4) control of payments to doctors for services in hospitals; (5) control of diagnostic and investigative services; and (6) inclusion or exclusion of specific activities from Plan benefits; (7) patient participation fees; and (8) alternatives to fee-for-service system of renumeration.

<u>Report #8</u>

No short synopsis as this report dealt with responses to specific reports.

9. <u>Review of the Ontario Parcost Program.</u> A Report of the Ontario Council of Health. 1973.

A review of the existing Parcost Program and 11 recommendations dealing with:

(1) dispensing of prescription drugs and the use of generic terms;
(2) responsibilities of Drugs and Therapeutic Branch with respect to including drugs in CDI;
(3) increasing public, practitioner and agency awareness of the program;
(4) means of expanding the program.

10. Report of the Task Force on OHIP Cost Control: Vol. I. Physicians and Laboratory Services. Treatment and Rehabilitation Division. Ontario Ministry of Health. 1973.

A. Two methods are presented for controlling the costs of physician services in a program dominated by fee-for-service payments. The methods are: (I) control by regulation, and (II) use of a global budget. The former is based on the adoption of a provincial schedule of benefits rather than the profession's schedule of fees. The latter would require setting a ceiling upon expenditures in each fiscal year.

B. Control of laboratory costs could be achieved through regulation, global budgeting or alternative methods of financing. Controls must be placed on both price and utilization. One global budget from which laboratory and medical services would be reimbursed may provide a disincentive to over-utilization.

11. Report of the Task Force on OHIP Cost Controls: Vol. II. Payments to Chiropractors, Osteopaths, Chiropodists, Optometrists and Dentists. Treatment and Rehabilitation Division. Ontario Ministry of Health. 1973

A. Recommendations for controlling cost of payment to Chiropractors, Osteopaths and Chiropodists were:
   (I) eliminate radiological services provided by these practitioners from OHIP services;
   (II) establish a maximum payment for chiropractic or chiropody services;
   (III) negotiate a reasonable fee schedule above which practitioners could not bill;
   (IV) inclusion of practitioners as part of health care team.

B. Recommendations for controlling cost of dental services were:
   (I) elimination of specific services from OHIP benefits;
   (II) elimination of requirement of hospitalization as a pre-requisite for payment for the remaining 23 insured dental services;
   (III) begin planning for a children's dental program.

C. Recommendations for controlling cost of payment to optometrists were:
   (I) no constraining action at present time;
   (II) explore means of extending their role and involving them in organized settings.

12. Report of the Task Force on OHIP Cost Control: Vol. III. Clinical Education System and Radiology/Pathology Hospital Services. Treatment and Rehabilitation Division. Ontario Ministry of Health. 1973

A. Clinical (medical) education receives funding through (I) financial support for geographic teaching staff, that is 50% (up to $15,000.) of guaranteed income or salary accepted as hospital budget expense; (II) fees for clinical services; and (III) salaries for interns and residents. Recommendations were:
   (I) development of a system to ensure that payments are for administrative duties as compensation for loss of fee-for-service income;
   (II) detailed review be done of existing system.

B. Present contracts between hospitals and physicians (radiologists and, to a lesser extent, pathologists and medical specialities) inconsistent with OHIP payment policy. Recommendations were:
   (I) Dissolve all existing contracts which are inconsistent with plan payment policy;
   (II) re-negotiate contracts in which incentives to merely increase volume is either minimized or mitigated by other incentives;
   (III) control laboratory costs in general through constraining growth of commercial laboratories, establish separate cost centres for hospital labs, develop a global budget for commercial labs, develop relative value free fee schedule.

13. Report of the Laboratory Studies Committee. Ontario Ministry of Health, 1976.

Recommendations were made with respect to 5 major areas. (1) Physician utilization, (2) co-ordination, (3) adequacy and efficiency of the information system, (4) funding of laboratory services, and (5) the formation of an intra-Ministry laboratory services co-ordination committee.

Recommendations were directed toward:
(1) ensuring appropriate utilization of laboratory services by physicians;
(2) increasing provider awareness of costs;
(3) development of a comprehensive laboratory service information system;
(4) developing a mechanism for the co-ordination and integration of laboratory services;
(5) developing an equitable funding mechanism for laboratory services in the public hospitals, public health and private sectors;
(6) providing necessary legislative authority to control operation of licensed laboratories;
(7) developing a mechanism for co-ordinating all maintenance and developmental laboratory services activities and to ensure implementation of the Ministry overall plan to control costs.

14. <u>Control of Private Laboratory Costs Through Tendering.</u>
Ontario Ministry of Health. 1970.

The validity of tendering as a mechanism to control the increasing costs to the Ministry of Health for private laboratory services cannot be proven at this point in time. Improvements in management and control of laboratory services may allow Ministry adequate time to monitor a demonstration project (being conducted in New York City) and to gain knowledge. The basic concept of tendering laboratory services needs to be tested.

15. <u>Hamilton District Program in Laboratory Medicine.</u> Ontario Ministry of Health. A Report from Woods, Gordon & Co. 1976.

A study to determine and compare the costs of the Hamilton District Program in Laboratory Medicine as it is presently operated and the costs if it were to be run as an independent laboratory, assuming that it operated under the same OHIP fee schedule for licensed independent laboratories and with all cost allocations that would make it comparable to a licensed independent laboratory.

Findings: Hypothetical financial results reveal a deficiency of revenue over expenses for the total laboratory program and one hospital appeared to account for major portion of the deficit.

The findings of this report do not resolve the issue of whether hospital laboratories are more or less cost effective than private laboratories.

16. Report of the Committee on Health-Care Costs. Ontario Department of Health. 1971.

Three sectors of the health-care system were reviewed with respect to costs: hospital services, physician services and community health services.

Recommendations were directed toward:
(1) appropriate utilization of manpower resources, including manpower substitution such as nurse practitioners;
(2) appropriate utilization of resources, e.g. control of admissions, discharge and utilization; judicious use of diagnostic and investigative services;
(3) increasing provider awareness of costs;
(4) control of unnecessary services;
(5) centralization of services e.g. unification of community health activities, centralized laundry services for hospitals;
(6) provision of incentives to hospitals;
(7) development of home care as an alternative to institutionalization;
(8) alternatives to fee-for-service system of renumeration and alternative modes of practice;
(9) improvements in statistical data base.

17. Task Force Report on the Cost of Health Services in Canada. Committee on Costs of Health Services. Vol. I - III. (Summary). Ottawa: Department of National Health and Welfare. 1969.

Health is a labour-intensive industry. Regional organization of all health services, involving central co-ordination of many facilities and agencies, is essential to cost efficiency. Understanding and co-operation by the consumers is a necessity. Recommendations deal with:
(1) Regionalization;
(2) appropriate utilization of services;
(3) financial incentives to providers;
(4) appropriate utilization of manpower resources;
(5) alternatives to acute-care hospital facilities;
(6) co-ordination of specialized services;
(7) measures to increase effective, efficient management of hospitals;
(8) co-ordinated government planning.

18. The Ontario Committee on Taxation Report (Smith Report) Vol. I - III Ontario. 1967.

Acute care hospitals not being used appropriately and there are no financial incentives to hospitals or patients to move to less costly facilities. There is a need to increase public awareness of the costs of hospital care. Premiums yield roughly 1/3 of total financial resources required to meet operating costs is one means of increasing public awareness of costs. Direct patient charges may be considered. Patients need to be provided with receipted hospital invoice showing the cost of services rendered.

Regionalization should facilitate more economical and effective public health units and hospital facilities.

19. Taxation in Ontario: A Program for Reform: The Report of The Select Committee of the Legislature on the Report of the Ontario Committee on Taxation. (White Report). Ontario.

An indirect means of controlling costs and maintaining and/or increasing public awareness of actual costs is the use of a premium system. Premiums were perceived by some as regressive form of taxation and a more progressive form of taxation was advocated.

Recommendations: (1) maintenance of premium system;
(2) introduction of subsidized premium system to ensure that hospital care would be available to all residents regardless of ability to pay.

20. Evans, R.G. and Williamson, M.F. Extending Canadian Health Insurance: Options for Pharmacare and Denticare. Ontario Economic Council Research Studies. 1978

The report contains:
(I) a discussion of the objectives of public insurance programs,
(II) an examination of the pros and cons of pharmacare and denticare programs (costs would probably outweigh benefits),
(III) discussion of partial insurance plans which appear to be superior to universal plans; and
(IV) the reasons for expansion of private dental insurance.

21. Let Us Take Care. A Report to the People of Ontario. Ontario Nurses' Association. 1977.

The report focused on the following major areas: (1) inadequacy of facilities for chronic care; (2) misuse of acute-care hospital facilities; (3) wastage within hospitals; (4) need for co-ordination of health care services; (5) medical manpower substitution; (6) home care services; (7) use of public health nurses; and (8) nursing workloads in hospitals.

Recommendations were directed toward:
(1) development of assessment and placement services;
(2) conversion of existing hospital facilities or re-organization to accommodate need for chronic care facilities;
(3) integration of programs and services for the elderly;
(4) measures to ensure appropriate utilization of hospital facilities
(5) regionalization;
(6) medical manpower substitution i.e. expanded use of nurse practitioners;
(7) increased funding for and improved co-ordination of home care services;
(8) promotion of health and expansion of the role of the public health nurse;
(9) study of manpower and productivity in nursing services.

22. Ontario Public Health: Some Current Issues.
Ontario Ministry of Health. 1977.

This report contains a summary of identified, major problems in the public health system and a number of recommended policy adjustments. Recommendations were directed toward:

(1) development and implementation of a comprehensive policy and co-ordinated program for health promotion;
(2) expansion or modification of policies and programs to support the development of non-institutional treatment services;
(3) identification of the constituents of the public health system, goal of that system, clarification, and, if necessary, modification of responsibilities;
(4) cost-sharing arrangements;
(5) experimentation and evaluation of alternative modes of delivery of service.

24. Report of the Health Planning Task Force (Mustard Report)
Ontario. 1974

combined with

23. Report, Reaction, Response - The Health Care System in Ontario.
Ontario Ministry of Health. 1975.

The Task Force recommendations were grouped into 6 broad fundamental issues.

(1) Development of primary care.
(2) Rationalization of Secondary Care.
(3) Local involvement in health service planning.
(4) Redefinition of responsibility within the Ministry.
(5) Greater public involvement in manpower planning and control.
(6) Improvement in the delivered quality of medical care.

Reaction and responses to these major issues were elicited and are presented.

24. Report of the Health Planning Task Force (Mustard Report)
Ontario Ministry of Health. 1974

Development and implementation of a comprehensive plan for health care will affect health care costs. Six areas relating to control of health care costs that were discussed were:

(1) Financing of health care institutions - any health care facility obtaining funds from Provincial Government would be incorporated into proposed organization for health-care services (district and regional health councils).
(2) Remuneration of health professionals - system of fee-for-service is in need of modification and unit billing system is recommended.
(3) Remuneration for educational services - educational services should be paid out of education funds. Distinction must be made between education and service costs.
(4) Remuneration of specialists - e.g. primary care activities should be reimbursed at primary care, not speciality, rates.
(5) Financing of laboratory and Radiology Services - revision of benefits payable and payment of capital and operating costs of laboratories should be based on actual costs of providing the service.
(6) Remuneration of allied health care personnel - use of unit billing, enhance emphasis on preventive care.
(7) Premium system - no longer achieves original purpose .
(8) Control of health manpower - establishment of guidelines and exclusion of physicians who wish to practice in district that has no opening.

25. Spitzer, W.O., Roberts, R.S., and Delmore, Terry.

"Nurse Practitioners in Primary Care: Assessment of Their Deployment with the Utilization and Financial Index". Canadian Medical Association Journal. Vol. 114 (June 19, 1976) 1103 - 1108.

A report of the use of nurse practitioners and the effect on utilization of ambulatory services, and hospital services by population served and the economic effect on physician incomes. Findings included: increases in use of ambulatory services, reduction in hospital use and financial loss by physicians in physician - nurse practitioner teams.

26. The Nurse Practitioner in Primary Care. A Report of the Ontario Council of Health. 1975.

The report contains information and recommendations relating to:
(1) Definition of the role of the nurse practitioner;
(2) The need for nurse practitioners in Ontario;
(3) Training;
(4) Methods of remuneration;
(5) Regulation and control of practice.

27. Post-graduate Manpower (Boone Report) Council of Ontario Faculties of Medicine Committee Report. Council of Ontario. Ministry of Health. 1975.

Consideration was given to how medical manpower could be maintained at levels relevant to the needs of Ontario. Recommendations dealt with:
(1) Training Programs - establishment of objectives and allocation of training positions to the programs;
(2) On-going Study and Surveillance;
(3) Special considerations - immigration, academic positions; introduction of new training programs and need for consideration of factors which will influence medical manpower resources.

28. Report of the Special Study Regarding the Medical Profession in Ontario. (Pickering Report) Ontario: Ontario Medical Association. 1973.

The report contains an examination of the role of the medical profession and its relations with the public and Government in Ontario, the economic position of physicians and method of remuneration.

Recommendations deal with:
(1) Improving efficiency of practitioner practices.
(2) Expanding the role of paramedical personnel.
(3) Establishing a medical manpower data unit.
(4) Increasing consumer awareness of costs.
(5) Controlling physician abuse of the system.
(6) Correction of deficiencies in fee-for-service system of remuneration.

29. A Study of the Implications of Using a Personal Identifier in the Ministry of Health. Ontario: Management Consulting Services. 1974.

There is a need for a unique personal identifier and the Ministry of Health should adopt one for all its people oriented programs, including OHIP. The identifier should contain a uniquity assigned code or numbers for each individual and a check-digit of adequate discrimination. The Social Insurance Number should be adopted as the identifier and possession of such a number should be made mandatory for residents of Ontario. Control over all aspects of data gathering and the use and dissemination of information must reside in one central organization, the Ontario Statistics Board.

30. A Study of the Implications of Using a Plastic Identity Card For the Health Insurance Plan. Ontario: Management Consulting Division of Government Services. 1974.

A decision on the question of adopting an embossed plastic identity card for OHIP must be delayed until such time as the issue of a unique personal identifier has been resolved. When OHIP adopts a unique permanent personal identifier, the information for each participant should be contained on an embossed plastic card.

31. Report on the Evaluation of Chronic Home Care. Ontario Ministry of Health. 1977.

An evaluation of the expansion of Acute Home Care and Chronic Home Care Programs led to recommendations to continue with Chronic Home Care program for another 18 months, for a more extensive evaluation be conducted and for revisions in Home Care Information System.

32. Science for Health Services. Report No. 22. Ottawa: Science Council of Canada. 1974.

A restructuring of the health care system is seen as one means of reducing rate of cost escalation. Recommendations include:
(1) re-organization of system;
(2) redefinition of roles of personnel;
(3) enhanced protection of health;
(4) establishing priorities for research and development;
(5) determining effectiveness of approaches to health protection;
(6) organization and funding of research and development.

33. Health Care in Canada. A Commentary Background Study for the Science Council of Canada. (R. Robertson Report) Special Study. No. 29. Ottawa: Science Council of Canada. 1973.

This study examines the overall level, adequacy and appropriateness of research related to the development of a comprehensive and co-ordinated system of health care in Canada.

34. Regional Organization of Health Services. Report of the Ontario Council of Health. Supplement No. 1. 1970.

The 12 recommendations contained in this report relate to the establishment of regional and district health councils, their boundaries, composition, functions, relationships between regional and district councils and the role of the Provincial Government. Regional and district health councils to serve in an advisory capacity to the Government.

35. A New Perspective on the Health of Canadians (Lalonde Report) Ottawa: Department of National Health and Welfare, Government of Canada. 1974.

This report contains a discussion of the limitations of the traditional view of the health field; the role of human biology, environment and life styles in sickness and death of Canadians; a proposed conceptual framework for studying the health field; and an illustration of the use of the framework in the analysis of health issues and policy development. Two broad objectives are formulated, and five main strategies and seventy-two possible courses of action are identified.

36. Report of the Task Force on District Health Councils.
Ontario. Council of Health. 1975

A review was conducted of current guidelines, status and functioning for planned and existing district health councils in Ontario. The Task Force recommended the encouragement of district health councils for decentralized community-oriented health planning. The recommendations dealt with the establishment and composition of Councils; boundaries; relationships among Councils and with health science centres; responsibilities of Councils; Provincial level of Co-ordination; liability of Council and Committee members; and health councils in Metropolitan areas.

37. Health Research Requirements. Task Force Report. Ontario.

The report contains 48 recommendations with respect to funding of health research, research objectives and priorities, ensuring adequate, physical and manpower resources and appropriate utilization of resources; mechanisms for the co-ordination and control of health research.

38. Report of the Provincial - Municipal Grants Reform Committee. Vol. I. Chapter 7 & 8. Ontario 1977.

This report deals with the roles of Provincial and Municipal governing bodies with respect to financing health services; the role of Boards of Health; health-oriented services not incorporated at present in Ministry of Health programs; and funding anomalies in the provision of residential services to the aged.

39. Mental Health Services Personnel. A Report of the Ontario Council of Health. 1973.

Improvement in mental health services is seen as a result of bringing together the many workers in the mental health field into a single structure with common standards of competency that are recognized and certifiable. Clearly defining functions, and providing certification for those who demonstrate competence in performing these functions, is the means of regulating practice.

Recommendations related to the establishment of a College of Mental Health Practitioners; the functions of the College; clear definition of functions in the mental health field, and classification and certification of workers; according to level of competence, and discussion of the report and its recommendations by various occupational and professional groups.

40. The Planning Function of District Health Councils.
Ontario Council of Health. 1977.

The report provides a summary of the planning function of district health councils, rationale for the establishment of a network of relationships and the need for adequate resources.

41. Evaluation of Primary Care Services. A Report of the Ontario Council of Health (Spitzer Report) 1976.

A methodological strategy is presented for judging the performance and acceptability of primary care services. Detailed descriptions of all components, including indicators of performance, of the evaluation plan are presented. Recommendations are made for implementation of the strategy.

42, Report of the Royal Commission on Metropolitan Toronto (Robarts Report) Vol. 1-2. Province of Ontario (TEIGA) 1977.

Recommendations dealt with the designation of Metro Council as the District Health Council for Metro Toronto, the transfer of responsibilities for public health to area municipal councils, increasing Provincial grant support to 75%, the role of Metro Council in co-ordination of public health services and in the provision of statistical or other analytical services.

43. Health Research Priorities for Ontario. A Report of the Ontario Council of Health. 1977.

Recommendations relate to:
(1) re-affirmation of the Province's responsibilities to maintain a balanced and long-term research program;
(2) use of estimates of economic burden of ill-health in establishing priorities;
(3) establishment of priority areas - rationale provided;
(4) development of health-related record linkages;
(5) support for personnel;
(6) use of contract research.

44. An Estimate of the Economic Burden of Ill-Health. A Study for the Ontario Council of Health. 1976

Estimates were developed of the direct, indirect, and total economic burden of 18 major diagnostic categories of ill-health. The estimates of economic burden provide means of calculating social costs. An economic criterion should be applied to health research, that is, research in which social benefits outweigh social costs, should be supported.

45. The Economics of Health Research. Ontario Council of Health. 1973.

The report contains information on:
(1) the role of Government and public financing of health research;
(2) economic classification of research;
(3) rationale for increases in public funding;
(4) allocation of funds.

SYNOPSES OF THE REPORTS

An Integration of the Comments of Management Committee and Ministry Staff on The Report of The Joint Advisory Committee of the Government of Ontario and The Ontario Medical Association on Methods to Control Health Care Costs.

There are four documents with the above title, dated Jan. 17, Jan. 27 and March 31 and March 31, 1978. The comments, statements etc. contained in the four documents have been integrated. The Committee Recommendations are presented and followed by Ministry comments.

Recommendations Dealing with Cost Containment

1. That the Drug Benefit Plan in its present form not be extended to cover any new age groups or populations.

Recommendation should be endorsed within the context of the cost containment strategy. No current plans to extend benefits to additional client group. Acceptability by public and physician anticipated be neutral, negative by pharmacists. Administratively feasible.

2. That some over-the-counter drugs (for example, antacids, laxatives and vitamins) be removed from the list of insured drugs.

Removal of selected drugs from insured list is already under consideration within the Ministry, but has been rejected once by Management Board of Cabinet - would require a reversal of decision. A definitive list of non-insured drugs would be required and the issue of "medical necessity" versus abuse of benefits requires resolution. Anticipated acceptability: negative by public (among elderly and poor) negative by physicians who will have to explain changes to patients and negative by pharmacists - reduces the competitive position of small pharmacies. OPA supported the concept. Administratively feasible.

3. That a review be made of the regulations covering the frequency and amount in which single prescriptions are filled by pharmacists.

Current regulations limit prescriptions to a single month's supply. Practice could be changed to require pharmacists to fill prescriptions as ordered by physicians (e.g. 3 month's supply). This issue currently under review by OMA and OPA and contains elements of potential conflict between medical and pharmaceutical prerogatives.

Savings would be at least partially offset by an increase demanded in the dispensing fee and increased wastage of drugs. Large volume prescriptions would risk accidental drug misuse among some elderly patients.

This measure would not have significant impact on cost containment.

4. That an incurred cost statement be provided by the physician to each patient.

It is impractical to expect physicians to issue such a statement, particularly for laboratory services. If economically feasible the statement would be more appropriately produced by OHIP. The plans in other provinces provide this service.

Implementation could be costly if development of a cost profile for each patient is required. May contribute to greater patient awareness of costs.

5. That there be no expansion of insured services in any area without rigorous screening by appropriate professional bodies and by the Government. That the possibility of reducing the existing list of insured services and placing constraints on new technology be given serious consideration by professional bodies and by the Government.

In principle, the medical effectiveness of new procedures, technologies or treatments should be subject to evaluation by both Government and profession, prior to inclusion as an OHIP benefit. In practice, Ministry has exhibited a not unreasonable unwillingness to set itself up as the arbiter of what health services an individual really needs. Even if sound, objective decisions are reached, acceptability to the public and professionals would be a problem, particularly if the list of insured services is actually reduced.

Reduction in the list of insured services contains the potential for the medical profession to erode the comprehensiveness of coverage and restore the payment aspect to the physician/patient relationship in small steps.

The Consulting Services Branch has tentative approval to review the payment policy committee, previously disbanded. Already some previously existing OHIP benefits have been either restricted or eliminated but significant further reductions in the existing list seems unlikely. As physicians wish to maintain their incomes, de-listing some services will cause them to provide more of other services. (March 31/78)

Consideration should be given to re-activating the payment policy committee, OMA should be invited to suggest services for de-listing and assess cost and quality of care implications.
Rigorous screening and reduction in insured benefits may have significant impact on cost containment. Public and physician reaction may be negative.

The interest of the Committee with respect to placing constraints on new technology is unclear. The Ministry has, under some initial internal consideratio development of policy and procedure for control of high technology. The Consulting Services Branch is developing mechanisms for constraint of new technologies (incentive/disincentives, guidelines).

6. That, since physician supply invites demand on the public purse, medical school enrolment be reduced to a number compatible with the Province's announced physician/population ratio target consistent with maintaining quality of care.

Medical Manpower Advisory Committee is recommending that, rather than reduce Ontario Medical School enrolment the province should enforce immigration and licensing controls, i.e. limit licensing to graduates of Canadian Medical Schools. This would bring intake levels into balance with physician/population target. Ontario is estimated to require 670 physicians annually to maintain a stable ratic, and produce less than 600 medical graduates annually.

Major resistance would be encountered if support reduced to medical schools.

To effectively manage physician supply, controls on geographic and speciality distribution are also necessary. The Ministry has initiated physician manpower policy with both Federal government (immigration controls) and Ministry of Colleges and Universities (frozen medical school enrolments).

Review of data on current age/speciality breakdown of active physicians should be done in order to avoid possible future deficiencies. Current immigration and enrolment controls should be continued and the feasibility of extending the control to individual speciality areas should be investigated. The planning activities of the Medical Manpower Advisory Committee should be continued.

This recommendation would have significant impact in long term.

7. That several pilot studies aimed at testing the feasibility of developing standards for disease management in non-institutional settings be conducted under the direction of the Ontario Medical Association using the resources of the Health Sciences Centres, and the findings of the pilot studies be made available as soon as possible - preferably by the end of 1978.

This recommendation is the committee's sole effort to place an onus upon physicians for resource utilization.

Feasibility of conducting pilot studies is high, but the development and implementation of standards is less feasible. In addition to scientific problems in defining appropriate care for individual conditions, the implementation of these standards would also be controversial.
The impact of this recommendation, although significant in long term, could be considerably delayed. This issue should be discussed at next OMA liaison meetings and be expanded to include both institutional and non-institutional settings.

8. That the Minister of Health in consultation with the Ontario Medical Association and the Ontario Hospital Association develop a specific mechanism for achieving greater involvement of hospital medical staff and the Medical Advisory Committee in the administration (including the budgetting process) of each hospital.

The Ministry endorses increased physician accountability for costs generated in hospitals. The effectiveness of this recommendation is debatable, as the greater the involvement of practicing physicians in budgetting and resource allocation decisions, the greater their internal conflict between accountability for financial viability of the institution, and the maintenance of both high quality standards of individual treatment and personal physician income.
The incentives/disincentives in physician renumeration would have to be altered.
The impact of this recommendation on cost containment is unknown.

Greater involvement of medical staff in administration/management of individual hospitals is to be discussed with OMA and OHA at future meetings.

9. That, given the many submissions to the Committee which called for the creation of an incentive scheme to hospitals for cost control, the Ministry of Health and the OHA immediately start the feasibility of incentives to hosptials.

Previous incentive schemes, in the early 70's, allowed facilities to retain 10% of underspent budget. This approach had limited effectiveness in improving productivity.

Committee on Incentive is reviewing alternative incentive scheme proposals.

There is considerable resistence within the Ministry to financial rewards to administrators for doing their jobs; instead, delegation of responsibility and authority to Ministry program managers, appropriate monitoring techniques and cost accounting, and disincentive schemes should be developed to increase accountability of program managers and administrators for expenditures. (Non-monetary incentives might be appropriate alternatives).

Discussion with OHA of framework for collaboration to explore alternatives and discussion of feasibility of alternative incentive schemes with Management Board was suggested as well as review and update of the progress of the Committee on Incentives.

10. That each hospital board - in conjunction with its Medical Advisory Committee - require persistent review of discharge data by the hospitals Admission and Discharge Committee.

Existing mechanisms required by Accreditation criteria and the Public Hospitals Act, are not uniformly active or effective.

The Ministry has invested in the development of data systems to support the proposed activity e.g. HMRI and Placement and Support Service (PASS) information systems. Review of these data in a regularized and systematic fashion, together with standards for patient management in hospital settings, should be encouraged and even required. The specific mechanism for such review, and the specification of the board's role could be left up to the individual hospitals, with general guidelines to be set by the Ministry.

The financial impact of this recommendation would be significant in long term. Discussion will occur with OHA and development and integration of hospital data systems will continue.

11. That individual hospitals, through discussion with their medical staffs identify a list of surgical procedures which, unless exceptional reasons are documented, must be performed on an out-patient or day surgery basis.

This recommendation would have significant impact in cost containment. Hospitals have been encouraged to perform out-patient surgery for suggested procedures. Some 70% of hospitals do so to varying degrees.

The Ministry should prepare a recommended list (individual hospitals could add items). Allowance should be given for size of hospitals, and relative sophistication and availability of medical staff.

This measure would only effect costs if beds were removed from service. Renovation costs would be expected from some hospitals and monitoring would be necessary to ensure that the changes didn't act as a stimulus for unnecessary surgery.

Assessment of extent to which hospitals already apply such a list and which procedures are included is required.

12. That a prospective pilot project be undertaken to test the feasibility of methods developed to distinguish non-urgent cases from the more serious cases presenting in an emergency department of a large urban hospital.

Financial impact of this recommendation is considered not significant. The University Teaching Hospitals Association is currently studying the emergency departments in downtown Toronto to determine savings from restriction of service hours and amalgamation of departments. The information sought in this proposed pilot project may be available from the UTHA study. The Consulting Services Branch is studying the relative efficiency and effectiveness of emergency departments for certain patients under certain conditions.

The Ministry should assess the organizational arrangements, and operational criteria necessary to permit implementation of such methods as triage, or patient differentiation, and of the adjustments to other parts of the health system (e.g. clinics) to make such differentiation possible.

13. That health care providers in each local area devise a system suitable to that locality to assist physicians to place patients at the most appropriate level of care.

This recommendation is perceived as having significant financial impact on cost containment.

The concept is endorsed as part of Ministry's commitment to the rationalization of health care delivery and elimination of inappropriate utilization, and to local input into planning for local needs. The PASS (Placement and Support Services) information system will provide an assessment of appropriateness of placement, but as yet only a minority of hospitals are on the system. The Program Development Branch has developed a placement survey methodology.

In some areas, the operation of placement services is hampered by inadequate supply of lower level care beds. Planning guidelines would have to be specified by Ministry, for use by local DHC's in designing, implementing and operating such system.

The Ministry has under active consideration means of advancing the establishment and operation of placement services, and the PASS program.

14. That a thorough review of provincial administration and audit procedures for hospitals be undertaken to determine whether the current level of paper work can be reduced without compromising quality of care.

The financial impact would not be significant.

Many of the current reporting forms were developed to meet federal cost-sharing requirements rather than management needs. Revised cost-sharing arrangements allow greater flexibility and content and format of forms are being scrutinized carefully. The Hospital Data Committee, involved in the identification of all forms and data elements required of facilities by Ministry, will recommend reduction and/or elimination as appropriate. The Health Information Review project has been initiated to assess the appropriateness of information now collected by the Ministry, both in OHIP and hospital areas.

Financial support for such reporting as is deemed necessary should be assured to hospitals.

15. That the necessity of the current OHIP requirement for submission by hospitals of individual out-patient claim cards (particularly for radiology services) be reviewed.

Financial impact not significant. Intent is to substitute bulk billing for current system of individual claim cards, thus reducing claim card volume generated by hospitals and processed by OHIP district offices. Bulk billing streamlines the reporting and reimbursement systems, but has the disadvantage of loss of information of services rendered to individual patients, as ordered by individual physicians. This limits the potential for control in radiological and laboratory services.

The Institutional Division is working with OHA to develop a satisfactory means of presenting the required information. This is expected to be installed mid-year 1978, limited at first to radiology billing, and to be applied later to out-patient laboratory services.

16. That a pilot project District Health Council be set up whose membership would consist primarily of physicians, health care administrators and others directly involved in providing health care services; and that it be given fiscal responsibility for the area's health services...although not for OHIP disbursement to MD's and other practitioners. Such a pilot project would afford an opportunity to assess the effectiveness of a more autonomous council -- albeit working under Ministry guidelines -- but determining and implementing local needs.

Approval would imply a reversal in Ministry policy and planning, to a provider -dominated council contrary to increased consumer participation in decision - making affecting their local health needs. Retention of the advisory role of DHC's is advocated by Ministry rather than addition of another level of fiscal authority. It would be unreasonable to expect providers to make decisions for improving the effectiveness and efficiency of the system, but which could act to constrain their own independence and budget/income. Incentives for achieving system goals would be required. The Government is unwilling to intervene to that extent in the activities of hospitals and professionals.

Evaluation of the proposed project itself would be problematic, if not impossible. Process and product of planning of DHC's are difficult to define and measure, there is variety in leadership styles and professional competence of the executive directors and chairmen of the councils. Implementation would imply that Ministry has been able to specif precise planning roles, responsibilities and relationships of the DHC's, the Ministry and the provider institutions.

Ministry should continue to work with DHC's to develop their potential capabilities within their current advisory role and will continue to assess how their contributions to the health care system can be further enhanced.

Cost Saving Suggestions Submitted by Outside Organization/individuals.

1. Accountability

Increase accountability of providers for the manner in which health dollars are spent, and of consumers for the demands they place on the system. Difficult to operationalize.

(a) Physicians and other Practitioners

- OHA monitoring of utilization of radiology, laboratory and nuclear medicine departments in hospitals
- provision of feedback to all physicians as to the costs generated by individual practices, both in institutions and their own offices, for laboratory and radiological services and consulting fees. (Physician profile system may provide this information on individual practices and for peer group comparisons).

(b) Facilities and Programs

Develop an information system which would provide valid comparative statistics on productivity and costs between hospitals.
(Health Information Review and Hospital Data Committee projects currently involved with this issue. e.g. HMRI and 106 data systems are being amalgamated to produce more useful information.)

(c) Consumers

Develop a system which would routinely aggregate all services provided to each consumer.
(The addition of a unique personal identifier would allow data from current OHIP and hospital data systems to be combined to provide this information on each consumer).

Use information as a basis for hospital budgetary allocation and as a means for detecting physician or patient "abuse" of the system.
(Ministry has initiated many accountability mechanisms, particularly in the areas of facility/program audit and monitoring of hospital utilization and physician services.)

2. Elimination of Duplication/Surplus

(a) Health care professionals

- control the output of all types of health professionals from the educational system.
- control distribution of health professionals throughout the province
- establish staffing ratios for hospitals and nursing homes.

(b) Active treatment hospital beds

Reduction in active treatment beds, balanced by an increase in hostel, chronic care and home care capacities.
(Ministry's position - reduce active treatment bed ratio to 3.5 by 1982)

(c) Specialized diagnostic and therapeutic equipment and services

- control on a regional basis high technology and specialized services
- share services between hospitals e.g. obstetrical and paediatric units
- regional system of parent and subsidiary hospitals which would share accounting, medical records etc. (Has considerable potential and should be explored further)

(d) Radiology and laboratory testing

- improve coordination between individual physicians and hospitals
- assess methods to ensure that x-rays and test results are shared at least between hospitals in the same region

Several submissions suggested a review of the entire extended care part of the system
- inequities in patient charges between hospitals, nursing homes and homes for the aged
- expansion of home care programs

(Ministry has initiated a review of geriatric health care services, including consideration of policies and procedures for modifying the long-term care bed guidelines and applying them in local situations.)

One submission proposed testing the validity of modifying the role of hospitals towards community health centers.
(Ministry interested in assessing the potential of the proposed rate change for hospitals)

Letters from the public made virtually no reference to Recommendations 4, 6, 7, 9, 11, 13 and 16.

3. Health Care in Canada: A Series on the Nation's Health.
J.E. Bennett and J. Krasny. The Financial Post. March 26 - May 7, 1977.

Health providers and the public need to know that resources for health services are limited. The government must establish and communicate specific limits. Three basic strategies for dealing with the current health care delivery system and one for dealing with health promotion are:

1. Ration Resources

Ration the flow of new resources into the health care delivery system and ensure that they are targeted at areas of proven health need.

(a) Keep the growth of the total wage bill of health care workers in line with other sectors. Government should establish and make known the maximum average annual increases they will fund in the future. Setting limits on total wage bill allows room for collective bargaining in that one category of worker may negotiate for fewer personnel in return for higher wages or reduction of disparities with other workers.

(b) continue a moratorium on hospital construction except where need is conclusively proven

(c) limit specialized new programs and diagnostic equipment to essential health centres

(d) growth in physician-to-population ratio must be slowed and incentives established for working in underserviced areas.

- hold the line or reduce enrolment in medical shcools, keep immigration of foreign medical graduates to a minimum.
- recruit more medical students from underserviced areas, require foreign graduates to practice in underserviced areas and establish more attractive financial incentives for physicians to move there.

2. Slim Hospital Structure

Slim down the existing hospital structure, channeling freed resources into the lowest cost, highest-quality form of care.

(a) establish bed-to-population standards and ensure they are met through closings or consolidations.
Consideration be given to weightings reflecting the hospital needs of various age groups, and perhaps geography and size.

(b) direct resources to high-quality, lower cost forms of care e.g. ambulatory services, home care, long-stay institutions.

(c) decentralize rationalization and deployment decisions
- region should be allowed to make decisions regarding bed-closings, consolidation and how and where freed resources will be re-invested in lower-cost forms of care or new programs.

3. Establish Incentives

Establish positive incentives for the providers of health care to use the system wisely.

(a) Pilot test new approaches to physician remuneration.

Fee for service system rewards doctors who maximize the volume of their diagnostic and treatment services.

(b) Encourage the formation of global medical practices.

- can cut hospitalization while providing high quality care
- provides lifestyle advantages.

(c) Revise hospital budgeting systems to provide administration and medical staff incentives to use less costly forms of treatment.

- Administrators and medical staff should be allowed to keep a portion of savings for needed new programs or equipment
- need to provide hospitals with positive incentives to improve operating efficiency and reduce use in form of inappropriate admissions and overly long stays.

4. Health Promotion

Place a major effort behind a limited number of high-impact health promotion measures.

(a) upgrade health education in schools
-Children need primary skills to be responsible for their own health. Requires a major upgrading of health education at elementary and secondary levels and input of facilities and teaching support.

(b) Saturation Training in Safety Oriented First Aid
-Considerable working time lost through industrial accidents and compensation claims have risen. Industries who provide employees with safety-oriented first aid have shown gains in reduced accident rate.

(c) Institute tough measures to reduce car accident injuries and deaths.

(d) Capitalize on the potential of voluntary organizations. Developing role of voluntary organizations could expand resource base and strongly influence behavioural patterns toward illness prevention and self-help.

4. Issues and Alternatives. 1976. Ontario Economic Council.

Two solutions invariably proposed with respect to the problems of inefficient production of medical and hospital services:

(1) Consolidation of small, independent provider into larger units i.e. group practice, community health centres etc.

(2) Substitution - the greater use of relatively more abundant and/or less expensive resources, especially manpower, for relatively more scarce and/or more expensive resources e.g. nurses performing tasks performed now only by physicians.

A. Consolidation (1) solo versus group medical practice.

Some studies corroborate argument that group practice results in economies but these studies are of questionable validity due to methodological and data limitations. Other studies are skeptical of benefits. Benefits other than lower unit cost practice do occur, e.g. more economic use of patient time, better use of medical manpower because manpower substitution along functional lines is possible, higher quality of medical service due to greater availability and specialization and more peer review possible.

The Council believes that group practice would allow for the implementation of a number of reforms that would take longer and be more difficult to implement independently. These include:

1. Alternatives to the fee-for-service payment system, the most likely alternative being either capitation fees or a salary system.

2. Medical manpower substitution and, hence, better use of personnel.

3. Improvement in the distribution of health services geographically.

4. Greater accessibility to a greater range of health care services resulting in improved continuity of care to the patient and economy in the use of patient's time.

Group practices incorporating these features may result in significant improvement in the delivery system and control of expenditures.

Issues and Alternatives

Hospitals

Maldistribution of hospitals exists in Ontario with resultant high costs. Surplus of acute care beds generates wasteful incentive to fill them and results in high rate of utilization. Real relevance is not the size of hospitals but the overall configuration of hospital facilities within an entire region. There is no consensus regarding the optimal size of hospital that will maximize efficiency of operation. Unnecessary duplication of expensive and highly specialized capital equipment and treatment units exists in some centres.

Recommendation Although there is no concensus regarding the optimal size of hospitals inefficient small hospital facilities do exist and should be closed or converted to community health centres or nursing homes.

Regionalization of the health care system may overcome some of the difficulties associated with planning and implementation changes in distribution of facilities. The Council encourages further adoption of District Health Councils (gradual implementation by the Government of regionalization concepts).

Recommendations made by the Councils to the Ministry of Health and subsequent decisions taken by Ministry should be made known to the public.

B. Substitution Hospitals - Alternatives i.e. Nursing Homes.

Over-emphasis has been given to active treatment hospitals. Programs and facilities that provide an alternative to acute care hospitals need to be developed as substitution for acute care hospital facilities. Simultaneous reductions must be made in the resources devoted to acute care hospitals.

Manpower Substitution

Many functions currently performed by medical personnel could be performed by less expensive personnel. Medical substitution could result in gains in productivity and reduction of expenditures. Constraints to manpower substitution include (a) increased professionalism and unionization of health manpower in hospitals, (b) fee-for-service method of paying doctors (c) existing licensing and legal constraints, (d) risks inherent in delegating tasks (e) consumer reaction and/or non-acceptance, (f) protectionist behaviour by physicians and dentists, (g) political and bureaucratic inertia and/or temerity in legislating changes.

Issues and Alternatives

Council

The Council's concensus is that the implementation of functional changes must be predicated on the elimination of the barriers to effective substitution. Attention needs to be given to reducing,if not eliminating entirely, these constraints.

Technical Changes

Substitution of capital for health manpower-i.e. electronic computer is seen by some observers as an alternative. The economic, legal, ethical and psychological implications have not been identified and need to be explored further.

C. Financing Health Care - The Incentive System

Incentives to patients, physicians and hospitals to reduce the aggregate utilization of health care services is one set of measures to contain growth in expenditures. Incentive system must be congruent with the delivery system. Solving financial problems without solving delivery system problems can be disastrous. There is a paucity of data and evidence regarding various approaches to the incentive system.

(a) Cost-sharing by patients

The present premium system is not related to risk and use of services and can have no impact on use of services. The premium system does not inculcate awareness of cost of services used. There is no empirical evidence that patients abuse the system. Deterrent fees place the onus on the patient to determine whether one is sick or not. They may deter consumption of preventive services and the Saskatchewan experience indicates that they result in decreased use of services by the poor. The Council believes that some portion of cost should be borne by patients and these should be related to use of health care services. If feasible, premiums should be related to risk as well as usage. There should be ceilings on the amount of cost-sharing and consideration to ability to pay.

(b) Incentives to Physicians

The physician is the key decision-maker, and any cost and utilization controls must affect how decisions of physicians are made. Demand for care is determined to a considerable extent by supplier-provider. Current fee-for-service method is devoid of incentives to increase efficiency and encourage economy in consumption of services. Alternative systems of remuneration,e.g. capitation, salary, have both positive and negative features. All are quite flexible and subject to a number of variations in basic design. It is imperative that financing of medical services be reviewed.

Issues and Alternatives

(c) Incentives to Hospitals

The current method of reimbursing hospitals lacks incentives to control costs. The role of hospital doesn't allow it much control over utilization of out-patient services, emergency departments etc. Physicians have considerable power over resource allocation in hospitals.

Recommendation (1) Interim solution. Examine each major hospital operation in order to identify areas where cost-saving technology can be introduced and to identify procedures and/or programs in which cost savings are likely. Such a review could be done by a team of experts.

(2) Incentive reimbursement program should be focused on "prices" - hospitals negotiate to deliver hospital care at a negotiated fixed cost per case, adjusted for diagnosis, severity, length of stay. Hospital would be reimbursed according to case load multiplied by schedule of costs per case.

(3) Per diem cost basis for reimbursement generates wasteful incentive to fill beds and is not advisable.

(4) Other features of the health care system, such as lack of alternatives to acute care hospitals, need to be reformed.

D. Prevention We do not have sufficient understanding of the interplay of social, biological, psychological and other factors that modify behaviour. Increased emphasis on prevention can lead to economic savings and gains in health condition. The optimal amount and type of prevention activity is not known. Serious consideration should be given to the use of incentives or disincentives to encourage or discourage consumer behaviour vis-á-vis prevention through cost-sharing systems. There are worthwhile areas government could pursue, especially in areas of accident prevention.

5. Report of the Special Program Review November 1975 (Henderson Report). Chapter 8. Health Care 137 - 163.

A. Public Responsibility

The key to cost control was identified as adjustment in attitudes toward individual behaviour and environmental factors in preserving and maintaining health. Responsibility for health is being transferred back to the individual and to other areas of social concern. Importance of "healthy" life styles i.e. physical fitness, moderation in consumption of food, alcohol and drugs, and alleviation or elimination of health hazards in the environment i.e. seat-belt usage, need to be stressed.

Individuals need to become more aware of health services costs. Unnecessary or careless use of services needs to be discouraged. User charges would accomplish this end.

Recommendations The Ministry of Health in co-operation with the
14 medical profession and Ontario Hospital Association, be directed to provide the Government by April 1, 1976 alternative proposals for financial and other ways to increase public awareness of health costs and to discourage careless or unnecessary use of health services.

B. Hospital Services

A re-examination of public health facilities and services seems to offer the best potential for effectively controlling future increases in costs. More efficient use of existing facilities, more regional planning for anticipated needs; greater productivity on part of hospital staffs and development of alternative less costly means of delivering health services currently provided by public hospitals are major means of controlling costs in the hospital services sector.

There has been too heavy an emphasis on active treatment facilities and the development of less costly alternatives has been neglected. Essential that existing facilities be fully and appropriately utilized. Greater emphasis needs to be given to alternative modes of care. The hospital system is labour-intensive, but there is potential for more efficient use of staff without sacrificing the quality of care. Comparative statistics indicate that there are variations in paid hours of service for similar levels of performance. Staff levels are lower in a number of other Provinces.

Hospital Services

Number of trained staff may be reduced, greater use may be made of automated equipment and operating costs may be reduced. Standard ward care available is of high quality.

There is a need to improve the planning and co-ordination of services at the local level.

Recommendations

1. Before present hospital facilities are expanded or new facilities are added the Government and Hospital Boards together ensure that existing accommodation is being fully and appropriately utilized.

2. In larger urban areas, hospitals be required to specialize in selected medical and surgical procedures to achieve a more productive utilization of facilities and improved calibre of care.

3. Consideration be given to phasing out surplus beds and expensive treatment facilities in some hospitals, particularly those in or adjacent to urban centres.

   (Rural hospitals form a significant part of economical life of community and few alternative services available).

4. Public hospitals be authorized to increase substantially the daily charges for private and semi-private accommodations.

5. The Ministry of Health amalgamate the various funds that exist at present into a single capital fund for the construction of health facilities.

6. Grant formulae be standardized for all hospitals and a major local commitment of funds be required for capital projects, approval of plans to construct replacement facilities will be contingent on clear evidence that such facilities will be able to provide services at lower cost than those already in place.

7. There be a thorough examination of public hospital operating costs with particular concentration on ways of reducing the total paid hours of hospital staff, the objective over the next three-year period should be to improve efficiency and reduce costs by 10%, excluding the effects of inflation.

Recommendations

8. Efforts be continued to assess and develop economically feasible and effective alternatives to the public hospital system for the delivery of health care to residents of Ontario provided that these services can be operated at lower cost and ease the need for hospital facilities.

C. Medical Services

Physicians are key persons in the use of hospital facilities and services and the treatment of individual patients. The number of specialists has increased disproportionate to increases in number of general practitioners and increases in population. Medical schools foster the increase in specialists, the OMA fee schedule provides specialists with greater financial reimbursement, and status and working conditions are more favourable for specialists. Specialists use more complex technology and increase demand for specialized equipment, although in smaller communities the actual need for such equipment is small. The use of laboratory services has increased. Private laboratories account for increasing share of activities. Hospital laboratory services can't meet increasing demand, more sophisticated technology is resulting in more tests being ordered per sample, and physicians order more tests to document competence and as precaution against possible complications in diagnosis. Private laboratories also use aggressive marketing tactics. Control of medical service costs should focus on constraining the number of physicians permitted to practice in Ontario.

Possible mechanisms of control identified:

(1) Limit number of licenses that may be issued in any year - may conflict with Ontario Human Rights Code.

(2) OHIP establish a physician complement, meeting specific criteria of supply - other physicians allowed to practice but not reimbursed through insurance plan. This method may restrict user's freedom of choice.

Neither (1) nor (2) would provide for better geographical distribution.

(3) Control cost without limiting number of physicians:
Negotiate with OMA - establish formula for fee schedule that would reimburse physician for increased cost of living and provide incentives for reduction in use of services. Formula would establish amount to be paid from OHIP each year for physician services.

(4) Build in mechanisms to encourage use of services only when necessary. Of questionable value.

(5) Provide tax credit based on individual use of health services.

(6) Revise OMA fee schedule to discourage repeat visits - means of preventing doctors from encouraging unnecessary repeat visits.

Recommendations:

9. Government Act to ensure that ratio of doctors to population not be increased beyond the present level of one physician for every 585 people.

10. Government take necessary steps to control the total number of licensed doctors, the number and type of training posts, and the geographical distribution of both general practitioners and specialists throughout the province.

11. Plans to expand Ontario Medical Schools beyond present capacity be curtailed.

12. Training programs for doctors maintain an adequate supply of General Practitioners in the Province.

13. Reimbursement procedures for laboratories be examined with a view to controlling the volume and ensuring the efficient provision of services.

15. In the longer term, the government extend block funding to a locally-elected body for all aspects of health expenditure, excluding medical services, and initial steps be taken in this direction.

6. The Effect of Fiscal Constraints on Hospital Employees August 1974 (Deutsch Report).

Since 1969, methods taken to restrain growth in hospital costs have consisted primarily of fixed percentage units on increases in global budgets. More severe global budget constraints have been applied in recent years. Supplementary measures, such as reductions in bed numbers and freezes, have been applied in recent years.

These measures have had little success in coping with the basic cost problems and have had a distorting and uneven impact on hospital employees. Analysis indicates that the constraints had relatively little impact in the cost areas where influence and power were strong, such as demands arising from doctors, specialists and patients. The effects tended to fall more heavily on those areas where influence and pressure were weaker-i.e. in the period 1968-73, allowable salaries and wages per patient day increased by an average of 14.5% per year in the category of special services (professional and technical), whereas they rose by a much smaller 9.3% per year for nursing services, and 7.4% per year for general services (housekeeping and maintenance). During same period the total number of paid hours of work per patient day for nursing and special services combined rose from 8.5 in 1968 to 11.4 in 1973. Total paid hours of work per patient day for administration and general services combined remained at 4.5. Reasons for increased costs included: Increased range, sophistication and complexity of health services; rapid developments in medical sciences and greater availability of specialists; the lack of controls or imbalances in the range of available facilities; and the lack of incentive to reduce unit costs.

Recommendations:

(1) Fixed global budgets for individual hospitals be retained. Modifications would include:

(a) In determining percentage increase to be allowed in the base budget for any year, that it include provision for increases in the rates of salaries, wages and other benefits for all hospital employees. Increase should reflect fully and fairly rates of increase for comparable or similar occupations and employment in economy outside.

(b) Before any new program or facility be provided for, a rational plan should be developed on a regional basis to avoid costly and unnecessary duplication.

Recommendations contd.

(2) Base global budgets of every hospital be viewed on a line-by-line and cost centre basis every 3-4 years. Purpose: to study the levels and trends of unit costs. If levels and trends unfavourable, then appropriate deductions would be made in approved base. If favourable, hospitals allowed to retain an appropriate portion of savings in the approved base - incentive to accomplish long-run efficiency in operations.

(3) In addition to general fiscal constraints on global budgets, that a number of supplementary measures be instituted.

(a) Review of methods of payments for services involving hospital expenditures, with a view to establishing incentives which will encourage use of less expensive procedures, facilities or services, rather than more expensive. Where this is not feasible, appropriate controls should be established to achieve the same end. Matters requiring attention include:
   (i) the use of expensive hospital facilities and procedures when adequate and appropriate care can be provided outside the hospital or is less expensive facilities.
   (ii) the unnecessary and excessive use of procedures and expensive specialities when these are free to both the practitioner and the patient.
   (iii) the unnecessary proliferation of expensive specialist services of all kinds, occupationally and geographically.

(b) Review of nature and functions of all health-care facilities in each region, with a view to establishing an appropriate balance so that appropriate and less expensive facilities are available and thus the use of more expensive facilities avoided.

(c) Possible encouragement of more centralized services for hospitals on a regional basis, to reduce costly and unnecessary duplication.

7. A Review of the Ontario Health Insurance Plan. Ontario Council of Health. 1973.

Combined with

8. Ministry of Health Analysis of the Report, 1975.

Purpose of the review was to conduct a critical and objective look at the health insurance program as it relates to physician services - specifically with respect to the scope of benefits and schedule of fees as benefit payments. Areas covered included development or improvement of mechanisms to control abuse by health professionals and patients, reduction in acute care facilities as adequate alternatives are developed; medical manpower substitution; control of payments to doctors for services in hospitals; a variety of mechanisms for controlling use of diagnostic services; and inclusion or exclusion of specific activities from Plan benefits.

Recommendations relating to cost containment include:

1. Payment for primary care services be at general practitioner rate where the general practitioner rate is listed in the schedule of benefits. Patient who chooses to go to specialist for primary care should be responsible for any additional charges.

   Specialist rate be accepted only when there has been a definite referral and conditions of referral presented.

Comments from Ministerial Analysis of 1973 Report.

Primary care has not been defined conclusively. Public may have no recourse to general practitioner. Savings would not be large.

2. Studies on alternatives to fee-for-service payment be set up and evaluated. Quality of care, accessibility and cost be included in studies.

Comments (Ministry): Evaluation criteria difficult to establish, but efforts under way to set comparative indicators.

3. Mechanism be developed to enable patients to verify services and the costs of services rendered to them.

Comments (Ministry): Techniques for unique identifier under review.

Comments cont'd

4. Funding of OHIP be studied with view of having premiums account for 1/3 entire cost.

Comments (Ministry): Until patient abuse established, deterrent fees are not advisable.

5. (i) Development of adequate alternative facilities-i.e. Chronic care, Homes for the Aged etc., should be accompanied by reduction in acute care hospital beds (4 per 1,000 population served). Hospital space that becomes available should be used for other health purposes.

Comment Setting of target reasonable, but as number of active treatment beds decrease, the cost per bed will increase.

(ii) Specific services should be identified with particular hospitals and duplication prevented. Strong direction required to achieve effective consolidation. Effective measure required to co-ordinate the work of hospital boards where there are two or several hospitals in a community.

Comment (Ministry): Co-ordination of medical staffs and other health services also recommended.

(iii) Norms, or generally accepted criteria be developed for the use of hospital and other facilities in treatment and diagnosis, particularly in admission, investigation, length of stay and discharge areas.

Comment (Ministry): Until quality of diagnostic coding is improved and disease costing norms developed, concept cannot be effectively introduced.

6. Inclusion in medical practice of nurse practitioners and other ancillary personnel be viewed as an urgent matter. Factors such as implementation, legality and method of payment be resolved as quickly as possible, so adequate training programs can be established.

Comment (Ministry): Agreement exists but problem is identification of role, function etc.

7. For all elective admissions pertinent pre-admission investigations be available to the hospital at the time of admission. This should be a condition of admission.

Comment (Ministry): Agreement.

Comments cont'd.

8. Development of highly specialized services should follow the guidelines contained in the report of the Ontario Council of Highly Specialized Services.

Comment (Ministry of Health): Agreed. Funds allocated within this principle.

9. Experimental procedures such as heart transplants be excluded from Plan.

Comment (Ministry of Health): Adopted.

10. Effectiveness of management arrangements in hospitals be studied.

Comment (Ministry of Health): Being implemented at local level.

11.(i) Payment (to doctors) for patients in hospital on a per visit basis be accurately related to the service given. Criteria developed for hospital admission, utilization and discharge be maintained. Attempts should be made to define the cost a manner similar to surgical conditions. Equitable payments for the first day should be made with a more rapid scaling down

Comments (Ministry): A sliding scale has been suggested but not accepted by OMA. Criteria being developed.

(ii) Where more than one hospital arrangements should be made for one or a limited number of hospitals, be designated for after-hours or weekend emergencies.

12. Elective patients not be seen in out-patient departments unless they are being seen in an organized clinic.

Comments (Ministry of Health): Agreement exists on cessation of using department as second office.

13.(i) Insurance plan should only pay for diagnostic tests and procedures which are relevant and pertinent to the patients' conditions. Guideline criteria will be required.

Comments (Ministry of Health): Medico-legal implications have to be considered. Retrospective patterns necessary and control through MRC seems logical.

(ii) Payment to physician for services and technical component of diagnostic services be provided in hospital global budget.

(iii) The feasibility of paying private radiology clinics and laboratories on a budget basis be investigated.

(iv) Physician profiles be developed and analyzed in relationship to diagnostic services.

(v) Doctors should state the possible diagnosis or reason for tests be stated, indicate individually the tests required and sign the order form.

(vi) Laboratories be required to provide signed reports, technologists signature being acceptable if tests technical in nature, pathologist if diagnostic comments included.

(vii) Cytology specimens from one patient be submitted to only one laboratory.

Comments (Ministry) (ii) payment system under active consideration.

(iii) Mechanisms to effective control under review, budget being one, tendering another.

(iv) MRC responsibility - being implemented under expanded physician profile system.

(v) Administrative matter, mechanism for review of laboratory claims being considered.

(vi) Not implemented, physicians not convinced of value.

(vii) Specimens seldom sent to different labs and recommendation technically in effect.

14. Periodic health examinations, for plan purposes, be restricted to the following

(a) 5 years of life - 7 routine health examinations to be programmed at discretion of physician.
Ages 5-44 routine examination approximately every ten years.
Age 44 + - every 5 years.

(b) Routine Papanicolou test - no more often than every 2 years after age 20.

(c) Mammography and thermography as screening procedures not be accepted as a Plan benefit.

Comments (Ministry) (a) Essentially guidelines only and must be kept under review. Public must be advised that such restrictions are not intended to reduce effective preventive measures. Not implemented due to existing contention.

(b) + (c) Implemented indirectly by schedule of payments.

15. Immunization procedures be carried out by nurses under physician supervision. Excluded from Plan.

Comments Technically excluded but practice continues.

16. Procedures requested by third parties not be benefits.

Comments Agreement, but virtually impossible to implement.

17. Schedule items based on time units have actual times submitted rather than the number of time units.

Comments Would materially assist plan, not implemented, resisted by OMA.

18. Selective criteria, to clarify difference between luxury and essential care be established for a substantial number of procedures and conditions.

Comments Easily said, difficult to do.

19. Unusual situations related to quality and volume of services be identified. Mechanism to be developed which would take unusual situations into account, with appropriate action being taken when necessary.

Comments To some extent identified by OSPF which will be supplemented by patient profiles under development.

20. Justification for assistant fee be given when physician other than referring physician assists at an operation.

Comments Justification should be forthcoming, monitoring problems great.

21-28. All deal with specific procedures, services that should be excluded - many have been implemented. Others not implemented due to social implication.

29. Consideration be given to designating Student Health Services as extended care facilities.

Comments Scheduled to be programmed, not a priority item.

30. Surgi-centres be examined and compared with similar facilities in hospitals and comparative costs and quality of care be determined.

Comments Concept not in favour, due to plethora of existing out-patient facilities.

9. Review of the Ontario Parcost Program. A Report of the Ontario Council of Health. 1973.

Terms of Reference:

To review the Parcost program to evaluate and establish whether, in its existing form, it is achieving its objective to provide prescription drugs at reasonable cost for the people of Ontario: as well as to suggest possible amendments to be considered, which would make the program more effective.

Two methods undertaken by the Government of Ontario to provide assurance to doctors, pharmacists and other prescribers and purchasers, that some less expensive preparations are safe and potent and could be prescribed and dispensed with confidence in their quality were:

1. extension of its program of testing drugs purchased by tender, to include a larger list of those used more generally; and
2. institution of inspection and approval of manufacturers of selected important drugs.

The Parcost Comparative Drug Index was prepared. An agreement was reached between Ontario Pharmacists' Association and co-operating pharmacists which obliged those pharmacists to dispense, when possible, only the products listed in the Parcost Index, using an agreed formula for pricing. Bill 144, passed in July 1972, amended the Pharmacy Act authorizing dispensers, unless otherwise instructed by the prescriber, to dispense an interchangeable preparation listed as lower in price in the Parcost Index instead of the preparation named in the prescriptions.

Expenditures in 1972 for the Drug and Therapeutics Branch of the Ministry of Health totalled $839,000. Included were the administrative and laboratory costs involved in operating the Parcost Program, Drug and Therapeutics Committee, Extended Care Drug Program and the Provincial Institution Drug Purchasing Program. The Parcost Program has contributed significantly to saving the public of Ontario money (more than $5,000,000 in 1972) and the cost of the program is justified.

There is a high degree of voluntary co-operation with the purpose of the program. There continues to be vigorous opposition by interested parties to the concept of interchangeability of even carefully tested and selected preparations of chemically equivalent medicinal products. The Task Force was satisfied that the Drugs and Therapeutics Branch and its Advisory Committee are using the best available modern methods for evaluating drugs admitted to the Parcost Comparative Index, and are using admirable and objective judgement in approving or rejecting candidates for listing in CBI.

Recommendation

That further legislation be developed to make it clear that when a prescription written in generic terms for a product listed in the Parcost Comparative Drug Index is dispensed, selection of the product shall be from the C.D.I. list and all applicable terms of Section 52 of the Pharmacy Act 1972 shall be fulfilled.

Rationale: At present, if a prescription is written in generic terms, the pharmacist is permitted to select any preparation in his inventory which corresponds to the description. The selection could be the most expensive or could be cheapest, but of a quality not approved for inclusion in Parcost Index. If pharmacist not under a Parcost contract, he could charge any price he chose.

2. When a prescription written in generic terms designates a product described in the Comparative Drug Index as not interchangeable, the prescriber's intention must be ascertained. (When a prescription originates in a hospital or other institution, it is difficult to identify the prescriber. Representatives of the College of Physicians and Surgeons of Ontario and the College of Pharmacy should meet with appropriate persons from the Ministry to resolve this issue).

3. No further legislation be introduced at this time to make selection of less expensive preparations by the pharmacist mandatory rather than permissive - - - a majority of prescriptions examined in October 1972 indicated the prescriber's wish that the most expensive product of its kind should not be dispensed, either by naming a less expensive product or by writing in generic terms.

4. Annual survey of prescriptions conducted by the Drugs and Therapeutics Branch in 1970, 1971 and 1972 be continued.

5. That the Drugs and Therapeutics Branch of the Ontario Ministry of Health continue to devote attention to the drugs that are not listed in C.D.I. with a view to their eventual incorporation in the C.D.I. or in a supplementary list for purposes of reimbursement programs.

Recommendation 6 dealt with establishing official channels for routine communication of information regarding the quality of drugs between the Drugs and Therapeutics Branch of the Ontario Ministry of Health and the Health Protection Branch of the Department of National Health and Welfare.

Recommendation 7 dealt with increasing public, health practitioner, and public and voluntary health and welfare agencies awareness of the program.

Recommendation 8 dealt with the need to arrive at standard definitions.

Recommendations 9-10-11 dealt with means of expanding the program.

10. Report of The Task Force on OHIP Cost Control: Vol. I. Physicians and Laboratory Services. Ministry of Health. 1973

A. Controlling the Costs of Medical Services

Two methods are presented for controlling costs of physician services in a program dominated by fee-for-service payments. The methods are: (i) control by regulation and (ii) use of global budget.

(i) Control by regulation involves a developing system of controls upon benefits and fees through adoption of a provincial schedule of benefits rather than the profession's schedule of fees. The government would set the levels and conditions of payments. There would be perpetual fiscal restraints, continuously modified to control "current" distortions. Utilization would be monitored by verification and development of physician profiles. An early commitment to a "package of constraints" by Cabinet decision and by delegation of authority to an implementation project is essential for the success of this approach. Decisions required within a tight-frame plan include:

(1) adoption of a schedule of payments, initially based upon 1971 OMA schedule.

(2) a relative value schedule must be developed to correct inequities of income between specialities and to provide financial reward for socially desirable services.

Cost reductions could result from:

(1) elimination of certain major benefits - eliminate direct specialists services and pay at general practitioner rates;

(2) development of relative value fee schedule would eliminate the necessity for (1) above;

(3) elimination of certain minor benefits of dubious value e.g. restrict unnecessary or undesirable procedures e.g. tonsillectomies, eliminate supportive care as defined by OMA fee schedule, limitation of one consultation per person per year within multi-speciality groups, restrict investigative procedures e.g. lab associated with annual health examination, reduce payment for each additional family member seen in the office on the same day, reduce number of routine visits for chronic care to one visit per month, etc.;

(4) modification of certain fee and payment methods
- fee-for-service laboratory service replaced with budget or contract,etc.
- support other health professionals as replacement for M.D. on a salary plus overhead.
- increase payments for specified office procedures by approximately 20% in order to reduce more costly hospital overhead.

This method of control is dependent upon rapid, valid feedback from the system and upon ability to react and respond quickly to undesirable changes occurring in claims submissions or patterns of practice.

(ii) Regulation through "global budget"

A ceiling upon expenditures in each fiscal year would be established. Regulatory controls would be required in anticipation of or to correct payment inequities as they become evident. The fee schedule would remain in the hands of profession, but ceiling on payment would produce pressure to change the schedule to more accurately reflect the relative worth of services and relative income of physicians. A fixed pool of funds allocated to fee-for-service physicians. No physician permitted to "opt out". Pool for fiscal year divided into 12 monthly pools, monthly pool represents the maximum amount that will be paid for services rendered that month. If total billing exceeds monthly pool, all bills will be pro-rated.

B. Controlling the Cost of Laboratory Services.

Difficult to control costs of laboratory services by regulations related to utilization. Most tests are ordered because the physician perceives them as necessary. It is possible to control the prices which the Ministry will pay for laboratory services. The three options presented for control of cost for physician services - regulations, global budget or alternative methods of financing. Predictable levels of expenditure can be achieved only if controls exist on both price and utilization. A global approach could be developed and implemented for laboratory services. A separate laboratory services pool might be established or simply incorporated into medical services pool. The latter would provide a disincentive to over-utilization, since physicians and laboratories would be in competition for same monies. The initial pro-rations in fees would occur and any subsequent modifications in fees would favour the survival or development of efficient laboratories. If fee-for-services payments are to continue then the existing fee schedule must be replaced. A preferable replacement would be a relative value schedule. Basis for such a schedule may be existing relative value scales such as D.B.S. units.

Primary control of costs would be achieved by:

(1) incorporation of commercial and practice associated laboratory payments with the global amount established for the medical care pool; and

(2) alternative methods of payments constituting an initial draw against the pool. Budget or tender may be applicable either to a broad range of services for an institution, community or to a few selected procedures for a region or the province as a whole.

There is a need for careful analysis of the respective merits of commercial, of practice associated and of hospital laboratories, and of public health laboratory network in order to define their respective roles. Meanwhile the expansion of commercial laboratories should be limited to those where medical necessity can be determined. Separate cost centres for hospital laboratories should be established and budget requests should be analyzed on a community or regional basis.

11. Report of the Task Force on Controlling The Cost of Payments to Chiropractors, Osteopaths, Chiropodists, Optometrists and Dentists. Vol. II of Report of The Task Force on OHIP Cost Controls. Treatment and Rehabilitation Division, Ministry of Health. April 1973.

A. Controlling the Cost of Payments to Chiropractors, Osteopaths and Chiropodists.

Payments have increased since coverage provided in 1970. There is no evidence that the services are substitution for medical services. The benefits are considered non-essential, and in many cases have a questionable contribution to health and well-being of patients. It would not be realistic to eliminate payment completely, as this would deny subscribers a benefit to which they have been previously entitled.

The number of practitioners is small and payments do not represent a large portion of the total health budget. There is evidence of abuse and inappropriate use of their services-e.g. excessive number of radiological examinations performed by practitioners who own their own equipment; present payment system doesn't require participation of practitioner in OHIP and in some instances, rates in excess of O.M.A. Fee Schedule are charged.

Recommendation
Immediate:

(1) Radiological services provided by Chiropractors, Chiropodists and Osteopaths be eliminated as Plan services and, in return, permit the practitioner to refer patients to radiologists.

(2) The maximum payment for chiropractic or chiropody services be $100 per contract rather than the present $100 per person.

There would be no change in the maximum for osteopaths.

Intermediate Action

(1) Establish a project team to study and negotiate a reasonable fee schedule above which practitioners could not bill.

Long Range Action

(1) Long range planning for the provision of health care should include the training of practitioners as part of health care teams, under more appropriate methods of payment such as salary plus incentive bonuses.

B. Controlling The Cost of Payment for Dental Services.

Current conditions lead to:

(1) unnecessary and costly hospital utilization-specific surgical procedures could be done in a dentist's office but currently covered by OHIP and patient pressure dentists to have procedure performed in hospital.

(2) discriminating against the dentists who do not have hospital privileges, as well as their patients.

(3) incentives for what modern dentistry considers destructive care - over 90% of the Plan's payments for the twenty-four procedures is for dental extractions. Remaining 23 procedures represent "oral surgical procedures" and count for less than 10% of cost.

Most of these procedures could be done in oral surgeon's office, dependent upon health of the patient.

Recommendations

(1) Eliminate payments to dentists or surgeons for "surgical removal of teeth, erupted, unerupted or impacted" as a Plan benefit. Hospital admission for extractions should still be covered under rates established by the former OHSC.

(2) Eliminate the requirement of hospitalization as a prerequisite for payment for the remaining twenty-three insured dental services. Payment would be required in hospital only when admission was medically necessary.

(3) Begin planning for a children's dental programme with a view to implementation in 1975-76.

C. Controlling the Cost of Payment to Optometrists

Controversy exists between optometrists and ophthalmologists regarding services that could be rendered appropriately by optometrists. OHIP pays $10 for optometric examinations and limits optometric benefits to one examination in twelve months. The Fee Schedule of Ontario Association of Optometrists sets the fee for an optometric examination at $15. OHIP recognizes opthalmologists fee at $15.

The percentage increase in payments to optometrists was 13.86% in 71-72, 8% in 72-73 and 5.48% in 73-74.

Limitation of the cost escalation not a necessity at the moment.

Recommendations

(1) Take no constraining action on optometric services at the present time.

(2) A joint project team be established to implement a plan to involve optometrists in organized settings such as community health centres, and to evaluate the costs and benefits of permitting them an expanded role as private practitioners in the system.

12. Report of The Task Force on OHIP Cost Control - Vol. III. Clinical Education System and Radiology/Pathology Hospital Services. Treatment and Rehabilitation Division, Ministry of Health. April 1973.

A. Controlling Costs and Rationalizing the Methods of Support For the Clinical Education System.

The Clinical education component of medical education receives government financial support via three routes:

(i) financial support for "geographic" teaching staff - staff of all clinical departments in teaching hospitals who hold a university appointment and who devote full or 50% or more of time to university-directed activities, irrespective of participation in in-patient or out-patient activities. Exclusions are psychiatrists receiving support from Mental Health Division, pathologists, radiologists and full-time research grantees working in the hospital. The Ontario Hospital Services Committee accepts, as a hospital budget expenses 50% (up to $15,000) of guaranteed income or salary. The university is responsible for the remaining 50% and 100% responsible for fringe benefits. Payments increased by 224% from 1967-1972 despite source of additional funds - OMSIP and OHSIP.

Agreement effective from December 20, 1967. Prior to that time clinical teachers rec'd honorarium for their services, paid directly by the university. Increases in medical school enrolment was perceived as increasing educational duties as clinical teachers and resulting in loss in fee-for-service income. New arrangements were required to compensate for loss of income.

Federal government was prepared to share in the cost to the extent that the work of these physicians in teaching hospitals related to administration and direction of programmes.

(ii) Fees for clinical services - clinical teaching staff generate fee income through services provided in the clinical environment. Ceilings were to be imposed on net professional income but may not exist in all centres. Excess earning by clinical education physicians become part of staff association funds and flow back into educational system-i.e. recruitment of more professional and technical personnel to provide service and to teach, facilitating research not funded from other sources, acquisition of equipment, etc. Circumvents hospital budget constraints.

(iii) salaries for interns and residents -

Interns and residents are traditionally part of hospital staff and are paid by the hospital. When Ontario Hospital Services Commission was introduced, payments to students became part of the plan's fiscal responsibility. Salary rates are negotiated by PAIRO and the Ontario Council of Administrators of Teaching Hospitals.

Since 1970, the Ministry has paid $100 per month per student during clinical clerkship (summer internship programme for fourth year medical students converted into clinical clerkship in 1970).

Difficulties with present system

(i) difficult to rationalize and control the amount of time a geographic staff may be allowed for private practice and the proportion of total professional income that might be reasonably derived from fee-for-service.

(ii) ethical problems of duplicate payment - staff billing for services carried out by interns or residents, perhaps in absence of 'supervising' physician.

(iii) difficult to separate out in any particular instance, amount of education, care and research involved.

3. General methods for government financing of the clinical education system: Modify Present System, Finance Individual Clinical Teachers Directly, Finance a Health Services Complex.

1. Modify the Present System

(a) geographic teaching staff funds

(i) limit geographic teaching staff funds to support administration duties only (difficult to define administration and possible loss of staff due to shift to service earning potential. Clinical research may be curtailed).

(ii) terminate payments to geographic teachers (consistent with general trend to transfer funding of educational programmes to M.C.U.; difficult to distinguish service and education component in a clinical setting, two Ministries would be involved as M. of H. responsible for service function remuneration).

(iii) terminate both geographic payments and fee-for-service billings and replace with salary, sessional, contract or incentive payment system. (Total payments would be reduced and total central control of dispersal of funds established, leaves hospitals and Ministry of Health in difficult position with respect to their responsibilities for patient care; difficulties arranging suitable contracts would be difficult.)

(b) Payments to Clinical Clerks, Interns and Residents.

More investigation and consideration must be given to payment of these individuals. Issues such as services rendered, possible duplication of payments, to whom is resident, intern responsible, need to be investigated.

(c) Fee-for-service

1. Constraints applied to OHIP medical payments would apply
2. Special constraints be designed - e.g. modified fee schedule, possible disallowance of staff association funds, development of sessional payments, more precise definition of when and how fees may be submitted for services performed by residents, interns.

(d) Ministry of Colleges and Universities

Few funds come from this source, insist that geographic teaching staff funds be matched fully by "hard" university funds.

2. Finance Individual Clinical Teachers Directly

Methods of reimbursement could be one, or combination, of following:

(1) a fee-for-service (according to modified fee schedule) for provision of care

(2) a salary for provision of care, with or without incentive bonuses.

(3) a salary for administration and teaching

(4) a grant for research

Would provide a more complete evaluation of clinical teachers' functions in, and value to, the system. Has disadvantages of I a (iii).

3. Finance a Health Sciences Complex

Give a health science complex a global budget. The budget, initially, to be determined by a variety of factors with emphasis on quantities of various outputs produced. Payments to individuals would be made out of global amount. Choice of payment methods left to complex but contractual arrangements would have to be acceptable to Ministry staff members - e.g. individual not on full salary would have service income generated only according to modified fee schedule.

Recommendations

System is complex, alteration required but must be done gradually. Control of payments already begun by not permitting increases in 1973/74 over 72/73.

(1) A system should be developed so that payments will be made in 1974/75 only in those instances where it can be demonstrated that payments are for administrative duties as compensation for loss of fee-for-service incomes, within terms of written agreement acceptable to the Ministry (including statement of duties, responsibilities, time requirements and ceilings upon income).

(2) At some time should be announced that all geographic staff payments will cease in 1975/76 unless they remain as part of new financing system which must be developed and complemented by April 1, 1975.

(3) Complete and detailed review of present payment arrangements and effect on clinical education system be started.

B. Payment to Radiologists and Pathologist For Hospital Services.

Most existing contracts between public hospitals and physicians (radiologists and, to a lesser extent, pathologists and other medical specialities) provide for payment in excess of 90% of Ontario Medical Association Schedule of Fees. - inconsistent with payment policies of the medical care plan. Hospitals honour these contracts through transfers from hospital global budgets. Contracts provide for remuneration of physicians by either or both of two methods:

(1) Salary for professional consultation by the medical staff and for professional consultation by the medical staff and for professional supervision of the department staff.

(2) Fees for services performed for professional services related to patient care services such as interpretation of specimens and films.

3 options for curtailment of present unsatisfactory system: Options essentially those measures suggested for control of all medical services:

(i) Regulations limiting the nature of contracts and of relationships with proprietary facilities;

(ii) imposition of a global sum, limiting expenditures for these services or incorporation within the medical care pool;

(iii) alternative financing methods.

Only proper method for payment is alternative to fee-for-service. Fee-for-service provides little incentive for physician to question inappropriate or unnecessary requests for services. Considerable public monies used to support their practice.

Payment based on initiative, performance, status and responsibility would be preferable to award based on volume of services.

Move toward salaries would and should be relatively insignificant in terms of Plan expenditures.

Use of global budget, within a hospital's global budget, for laboratory and radiological services, and established by the Ministry on the basis of a formula would be desirable but difficult to achieve at an early date.

A rational allocation of provincial funds to the various parts of its total laboratory system is a pre-requisite to any system of formula payment and global budgeting.

Recommendations:

1. Dissolve all pathologist and radiologist contracts which are inconsistent with plan payment policy.

2. Immediately renegotiate new contracts in which incentive to merely increase volume is either minimized or mitigated by other incentives. (Payments must be reasonably related to responsibility and time requirements and total earnings consistent with that of other specialities).

These recommendations are in addition to recommendations made with respect to controlling laboratory costs in general—i.e.:

(1) Curtail immediately further growth in commercial laboratories;

(2) Cease OMA Schedule of Fees for laboratory services as a schedule of fees for laboratory services as a schedule of fees and benefits by the Plan;

(3) Establish separate cost centres for hospital laboratories - not separate global budgets;

(4) Develop an immediate global budget for commercial laboratories services based on a formula payment;

(5) Develop a relative value fee schedule for laboratory services and coincidentally start a pilot project by tender.

13. Report of the Laboratory Studies Committee. Ontario Ministry of Health. September 15, 1976.

Five major areas in which recommendations were made were: (1) Physician utilization, (2) adequate and efficient information system, (3) co-ordination, (4) funding of laboratory costs, and (5) the formation of intra-ministry laboratory services co-ordination committee.

1. Physician Utilization

The physician is the agent with the greatest potential for influencing future cost trends. The physician is the source of referral of such procedures. Reasons for ordering tests include 1) medical necessity, 2) pressure by patients, 3) legal concerns and 4) vested interests.

Factors influencing utilization include: Lack of knowledge on part of some physicians regarding indications for such tests; costs of procedure and possible benefits derived; appearance of new tests, advertising and inducement by laboratories to physicians, teaching techniques in which over-utilization of laboratory services to confirm a suspected condition rather than selection of essential tests to establish a diagnosis, confirmation of diagnosis through laboratory tests to protect self in legal actions, desire to keep up with medical advances, easy availability of multiple lab.results because of technological advances and lack of uniform peer review.

2. Management Information System

No uniform laboratory service reporting system exists for the three sectors in the laboratory industry in Ontario. Reporting mechanisms exist but existing lack of uniformity and co-ordination invalidates meaningful analysis and inhibits progressive planning, particularly in respect of necessary rationalization of the industry (dollar magnitude of industry now exceeds an estimated $220 million - hospital laboratories accounting for 64.5%, private laboratories - 30%, and public health laboratories 5.5%).

3. Co-ordination

There is a need for a decision-making structure to facilitate review and analysis of information on a geographic basis, and engineer realignments of the service delivery system in accordance with decisions regarding allocation of roles within a defined geographic setting.

4. Funding of Laboratory Costs

Overall solution to constraining cost increases would be for the Ministry to work out changes in the location where lab. services are performed, so that the tests are performed at the lowest unit cost but without deterioration of laboratory services provided. There is no uniform cost information readily available for any of the categories of laboratories.

Remuneration to pathologists, in the majority of public hospitals, is calculated as a percentage of the total value of laboratory services. Any change in the basis of paying hospitals and any increase in volume would be of concern to pathologists and hospitals. Commercial laboratory services in general are convenience-oriented, both to the out-patient and the physician. Public hospital laboratories claim that fiscal constraints prevent them from taking on additional volume from out-patient tests.

Considerable investigative work is required before Ministry will be in a position to advocate and sell a particular uniform funding mechanism. There is disparity in current methods of financing public hospital, public health and private laboratories. There is a need to conduct in-depth studies of hospital laboratories, their resources and capability to absorb additional volume. Cost per test analyses in all sectors of the laboratory industry are required to determine which of the service providers in a given setting can deliver services at least expense without deterioration in quality of services.

5. <u>Intra-Ministry Committee</u>

There doesn't exist in the Ministry a formal, on-going mechanism for the co-ordination of all activities relating to the maintenance of laboratory service programs as well as to the development of long-term strategies.

6. <u>Legislation</u>

Changes in Public Health Act, 1970, Health Insurance Act, 1972, and Health Disciplines Act, 1974 will be necessary if recommendations are to be implemented.

<u>Recommendations:</u> 1. <u>Physician Utilization</u>

(a) To foster more effective and efficient ordering of laboratory services by medical doctors (i) Discussion among Ministry of Health, The College of Physicians and Surgeons, The College of Family Physicians of Canada, and the Ministry of Colleges and Universities to initiate physician re-education which should be ongoing and include:
(i) Re-education of the student level
(ii) Information to all physicians through correspondence and the Ontario Medical Review.
(iii) Information to all physicians through annual and semi-annual College of Physicians and Surgeons Reports.
(iv) Continuing education for all physicians.

(b) Standard laboratory test requisition form be developed and utilized in the institutional setting and that its use be made mandatory (Health Insurance Act would have to be amended).

(c) Laboratory test requisition form also be used as the Claim form to the Plan in the private laboratory setting (finalized and will take effect January 1, 1977). Use of this form be made mandatory (amendment to Health Insurance Act required and recommended).

(d) Appropriate changes be made in the Health Disciplines Act concerning conflict of interest.

(e) Ministry of Health provide physicians with information concerning volume and costs of generated lab services, together with comparison with local peers.

(f) Amendments be made to Health Insurance Act, so that OHIP would have a formal mechanism in law to refer to the Medical Review Committee of the College of Physicians and Surgeons of Ontario those physicians whose pattern of generated lab service is unusual.

(g) Since referring physicians should utilize the ability of the laboratory director concerning the advisability or the necessity of certain tests in individual situations, the role of the laboratory director should be appropriately defined in the public health legislation.

2. Management Information System

To develop a comprehensive laboratory service information system.

(a) Initial step - a linkage run be implemented, utilizing Section 4 of hospital data and amended public health laboratory data for 1975 period for consolidation with private laboratories return.

(b) Data consolidations generated by linkage run be provided to district laboratory committees for review and evaluation, and for identification of any unforseen difficulties and also possible future refinements.

(c) If consolidation proves effective and a need is demonstrated for projected services to be reported in terms of actual experience, consideration be given to the development of a reporting mechanism that would require, under regulatory provisions if necessary, uniform reporting of actual laboratory services information by <u>all sectors</u> of the laboratory industry.

3. Co-ordination

To develop a mechanism for the co-ordination and integration of laboratory services.

(a) A laboratory committee be appointed as soon as possible to provide impetus to the establishment of a three-tiered laboratory committee structure on a district, planning area and provincial basis.

(b) Terms of reference include:

(i) Development of comprehensive standards for the establishment; delivery and evaluation of laboratory services;

(ii) Organization of lines of communication and relationships within the provincial committee structure;

(iii) Establishment of an effective methodology for evaluating the efficiency of district and planning area laboratory advisory committees.

(c) Ministry clarity and enlarge upon terms of reference for District and Planning Area advisory laboratory committees.

(d) Lack of adequate and reliable comparative data base on volume, type of tests, cost ingredients for laboratory work performed in public hospitals, public health and private sector. Until such data is available, terms of reference for district and planning area advisory committies be confined to the gathering of basic data and development of proposals for improvement and maximum utilization of existing resources.

(e) Membership on District and Planning Area laboratory advisory committees include representatives from the public, hospitals, public health laboratories and providing laboratories or using laboratory services within the area for which committee is responsible.

4. <u>Funding</u>

To develop an equitable funding mechanism for laboratory services in the public hospitals, public health and private sectors.

(1) A cost accounting study be done by an outside firm of consultants, to identify the complete unit cost of laboratory services for both in-patient and out-patient services in the three segments of the total laboratory field.

(2) A compilation of the direct and indirect cost elements of operating hospital laboratories be done by Ministry staff and appropriate O.H.A. Committee.

(3) Freeze the basis of payments to both medical group practice laboratories and commercial laboratories for 1977, or until cost accounting studies are completed and implemented.

4. All commercial laboratories, as a condition of licensure, be required to submit annual audited financial statements providing cost and revenue data in a form prescribed by Ministry, beginning with fiscal year ending in 1976.

5. Hospital laboratories be funded on the present budget basis until cost studies completed and considered.

6. Upon completion of cost accounting study, and when variations in unit costs are known, a new fee schedule be developed for commercial laboratories by collaboration with the Ontario Association of Medical Laboratories. New schedule be divorced from OMA fee schedule.

7. When new commercial fee schedule is established, Ministry recognize the right of the OMA to continue to establish their schedule of laboratory fees, but base payments by OHIP to individual physicians or physicians in group practice for laboratory services on the new fee schedule established for commercial laboratories.

8. Ministry utilize the new fee schedule for commercial laboratories in determining both hospital laboratory and public health laboratory budgets.

5. Legislation

To provide the necessary legislative authority to control operation of licensed laboratories .

(a) Intra-Ministry Laboratory Services Co-ordinating Committee review the existing sections of the Public Health Act, 1970 and regulations dealing with health facilities. Objectives of the review to:

(i) Establish standards and guidelines against which operational deficiencies can be measured-such standards to be included in regulations under the act;

(ii) Evaluate the merits of requiring by law that all licensed laboratories have a qualified laboratory director;

(iii) Establish appropriate qualifications for laboratory director to be included in regulations;

(iv) Define the duties of the laboratory directory for inclusion in the regulations;

(v) Investigate the feasibility of developing a uniform laboratory requisition to deal with ordering in both private and institutional laboratories;

(vi) Investigate the feasibility of requiring all licensed commercial laboratories to submit annual audited financial statements to the Ministry as a condition of licensure.

(b) That the Ministry of Health not proceed with the proposed regulation under the Public Health Act, 1970 dealing with ownership of licensed laboratories.

(c) That the Health Insurance Act, 1972, be amended to require in law the following:

(a) physicians generating excessive services be identified by peer comparison, be referred by OHIP to the college of Physicians and Surgeons for review;

(b) the prescribed laboratory requisition form be the mandatory claim form for payment of laboratory services.

7. If the proposals contained in report are acceptable and adopted for implementation, an on-going intra-ministry laboratory services co-ordination committee be appointed immediately, to co-ordinate all maintenance and developmental laboratory services activities and to ensure implementation of the Ministry's overall plan to control costs.

14. Control of Private Laboratory Costs Through Tendering. Ontario Ministry of Health. 1976.

The validity of tendering as a mechanism to control the increasing costs to the Ministry of Health for private laboratory services cannot be proven at this point in time. Qualification "at this point in time" is both important and valid.

The nature of laboratory services doesn't fit the business community's understanding of tendering. That is, a system in which the supplier perceives tendering as an equal and fair opportunity to acquire business through competition, and the purchaser considers tendering an opportunity to achieve cost savings through competitive marginal pricing practices. Within the commercial understanding of the tendering process one expects to have a well-defined concept of the volume of the commodity to be acquired, unit cost or gross cost to be paid for this commodity, and the ability to evaluate the relative merits of competing bids in terms of quality of product and ability to deliver to quoted specifications. These are unknown factors at present. In addition, there is essentially only one purchaser, the government, so failure to obtain contract would be demise of service. Different tendering options would have to be assessed within the whole laboratory scene in Ontario. Unless one places quotas on volume, tendering can't realistically effect utilization practices. Cost per test could be controlled through tendering, but doubtful if tendering would control volume. Volume is determined by the utilization pattern of physicians.

Recommendation

1. That tendering does not present itself as a suitable solution to the control of the cost of the laboratory services presently being performed in the private sector.

   Improvements in management and control of laboratory services may allow Ministry adequate time to monitor a demonstration project and gain knowledge.

2. That the Ministry arrange, on a formal basis, to observe the pilot project to be conducted in New York City.

   Essential requirement is to test the basic concept of tendering laboratory services.

15. Hamilton District Program in Laboratory Medicine
Ministry of Health. A Report from Woods, Gordon & Co. February 1976.

Objective: To determine and compare the costs of the Hamilton District Program in Laboratory Medicine as it is presently operated, and the costs if it were to run as an independent laboratory, assuming that it operated under the same OHIP fee schedule of licensed independent laboratories and with all cost allocations that make it comparable to a licensed independent lab.

HDPLM (Hamilton District Program in Laboratory Medicine) operated by Hamilton District Health Council.

The report presents revenue, costs and statistical data. The report relates to a "Hospital Laboratory Model" of the program. The HLM reflects the following costs:

(1) costs of performing tests which are of a non-billable nature-i.e. tests for research, routine health examinations.

(2) the costs attributable to education and research by the pathologists and technologists.

(3) doesn't reflect costs incurred by independent laboratories but not by DMLP hospitals i.e. realty and business taxes reflects adjustments in respect to;

(a) services that may not be provided by independent lab for which both revenues and costs have been included in the Hospital Lab Model i.e. autopsies, isotope scans;

(b) services provided by independent labs, not included in the program for which neither revenue nor costs have been included in the Hospital Lab Model i.e. E.C.G.

Findings Hypothetical financial results reveal deficiency of revenue over expenses for the total Laboratory Program amounting to $220,000.

Although it is not possible to determine precisely hypothetical results of each hospital, each hospital appears to have excess of revenues over expenses except one (M.U.M.C.) which showed a deficit of $1,410,000.

Note In Report on Tendering the authors stated that the consultant's study of Hamilton Laboratories did not fully resolve the issue - opinion that hospital laboratories are more cost-effective than private laboratories.

16. Report of the Committee on Health-Care Costs
Ontario Department of Health. 1971.

Three sectors of the health-care system were reviewed with respect to costs: Hospital Services, Physician Services and Community Health Services.

Major recommendations ~~for~~ reducing or containing costs in hospital services focused on reduction in the number of persons employed, more satisfactory utilization of personnel, greater productivity from personnel; improvements in medical utilization - reducing volume of diagnostic and investigative services, controlling admission, discharge and utilization (includes length of stay); and more efficient operation-i.e. group purchasing of supplies, incentives for cost control, centralization of services.

Recommendations regarding physician services focused on non-insurable medical acts, more judicious use of diagnostic and investigative services, control of physician and patient abuse, the use of physician-associates, remuneration - fee-for-service most practical at this time,but other alternatives need to be explored, and modes of practice-i.e. economics of group practice needs to be tested.

The Community Service recommendations dealt with home care as an alternative to hospital-based care, unification of community health activities, improved staff utilization, the continuing role of voluntary agencies, need for improved statistics and continuation, but changes, in communicable disease control.

Specific recommendations were made with respect to all three sectors of health-care services.

Specific Recommendations

A. Hospital Services

I. Use of Personnel

1. Surveys should be undertaken in three or four hospitals on a sample basis, to establish guidelines for elimination of routine duties in nursing service.

2. Application of work-study techniques should be considered seriously by hospital management. These studies would be applied in areas other than nursing (already covered in Recommendation I).

3. Paper work and systems be improved by methods, systems and procedures studies.

4. Contract-out of services such as dietary, housekeeping, window washing, painting and maintenance.

   Total costs involved in doing this work in the hospital must be compared with contracting outside for the work.

5. The ratio of professional nurses to nursing assistants and other non-professional nursing help should be examined by every hospital. A more economical mix could be obtained.

6. Mechanical systems for hospitals should be carefully studied to determine their effectiveness, and guidelines developed which would take into account differing circumstances in the hospital system, and their application to these circumstances.

7. The number of hospital employees could be reduced if productivity incentive programs were introduced into hospitals, whereby employees and department heads would receive a share of savings which were effected after productivity had reached a suitable level of standard production.

II. Medical Utilization

1. Reduce volume of radiological, laboratory and other services.

(a) Criteria be developed relating to the use of standards with regard to radiological, laboratory and other services.

(b) Medical staff review to what extent the demand for laboratory and radiology services are the result of accreditation programs and requests of interns and residents. Discourage such high demand.

Specific Recommendations cont'd

(c) Methods and amounts for payments for diagnostic services be reviewed.

2. Controlling admission and length of stay.

(a) There should be an active admission and discharge committee in every hospital, and in addition, an active utilization committee.

(b) A change should be made, if necessary in the regulations under the Public Hospitals Act, to provide the administrator of a hospital with authority to follow up the recommendations of the admission and discharge committee or utilization committee with individual physicians, and if necessary to suspend their privileges until corrections have been made to the extent that there is no excessive utilization.

(c) Length of stay be one area reviewed under utilization committee.

III. Improving Hospital Operation

(a) Hospitals should be urged to inaugurate a program to make employees aware of costs and to encourage controlling of waste of materials and services. Examples of waste-saving arrangement should be circulated to hospitals.

(b) A joint Committee of the OHA, OMA and OHSC, or technical people who would represent them, should be appointed to study jointly what savings would be possible by a modified method of funding equipment.

(c) All public hospitals should be encouraged or required to enter into regional arrangements with other hospitals to purchase drugs, medicine, medical and surgical supplies, and other types of purchased materials, on a group-purchasing basis, with the object of effective savings in operating costs.

(d) Studies of hospital design and on efficient construction should be continued. Use of new materials which can lower maintenance costs and lower capital costs should also be subjected to continuing review.

(e) Principle and concept of incentive plan, as developed by Ontario Association and the Ontario Hospital Services Commission, should continue.

(Portion of savings will be retained by hospital).

Specific Recommendations cont'd

I. Type of Services

(a) Medical care plans should not insure luxury or unnecessary services.

(b) Experimental procedures and unproven mass procedures which are not in the fee schedule should not be insured.

2. Use of Laboratory Services

(a) The most economical method of performing laboratory services needs to be encouraged.

(b) Fees charged and payments should be related to the method used.

(c) When a patient is admitted to hospital for elective treatment, the necessary investigations which are carried out prior to admission should not be repeated unnecessarily.

(f) All radiological facilities and laboratories should be subject to inspection and approval by a recognized authority, in order to be eligible for payment.

(g) Laboratory or diagnostic procedures which are effective and practical for health surveillance should be kept under review.

3. Patient Participation and Abuses

(a) Notification to patients of sums paid to physicians is not practical and has no effect on controlling unnecessary utilization and abuse.

(b) There is no single method of general patient participation which is applicable to all situations. The imposition of utilization fees would benefit costs of the plan on a short term basis only. Some methods would discriminate against general practitioners and some would discriminate against the poor among the patients.

(c) Physicians who habitually overservice their patients, and patients who abuse their insurance, can be detected satisfactorily and in this way utilization may be controlled by administrative methods.

(d) If certain physicians or patients are guilty of over-use or abuse, their services should be paid for by the plan at a lower rate rather than cut all payments indiscriminately.

Recommendations cont'd

(e) Physician profiles should be developed as the best non-monetary deterrents to over-utilization or over-servicing.

(f) A unique number be assigned to every Canadian regardless of age. Wallet-size plastic embossed identity card could be made available to every Canadian. The unique number should be the Social Insurance Number.

(g) Physicians in training should be trained to be able to justify their use of diagnostic procedures, hospital admissions and drug prescriptions.

(h) Greater emphasis should be given to clinical approaches to diagnosis rather than relying on mechanical aids and tests.

(i) Guidelines should be formulated for the rational and practical prescription of drugs.

3. Manpower adjuncts

(a) Funds should be made available to train a pilot class of practitioner - associates and to evaluate their utilization.

(b) Medical care insurance should cover the services of allied medical personnel working under the direction of practising physicians. Payment by salary would probably be most suitable method of payment.

H. Remuneration

(a) Fee-for-service method of payment is the most practical and the least expensive method to operate.

(b) Capitation method of payment may destroy incentives and initiative and may only be suitable for large clinics. Future studies may prove or disprove this.

(c) Study should be made of alternative methods of payment.

(d) A study of group practices and multi-discipline practices should be made to determine whether they improve efficiency and effectiveness.

C. Community Services

I. Home Care (Alternative to hospital care).

(a) Co-ordination by medical officer of Health - may be based on a hospital or on a community basis.

Home Care cont'd

(b) Patient on Home Care shouldn't pay for services received that would be available on an insured basis if a patient were in an acute, chronic or convalescent hospital bed.

(c) Services required for entry to Home Care Program should fit the needs of the patient, not be limited by requirement of a given number of services or be cut off because of length of time services would be supplied.

(d) Admission of a patient and services supplied be on the basis of a physician's prescription.

(e) Nursing, physiotherapy and other skilled services be purchased from existing services wherever feasible.

(f) Should be part of a continuum of health-care services and should be financed in an appropriate manner.

(g) Overall costs of a service to an individual should be known and compared.

(h) Cost effectiveness of these programs should be subject to regular review and comparison.

2. Communicable Disease Control

(a) Control of communicable disease through effective immunization program. (A number of specific recommendations provided relating to immunization-i.e. community based programs for school children, adults).

(b) Unification of all communicable disease activities at the Provincial level under one program head to prevent duplication. This should result in better utilization of highly trained staff and a more efficient program. (A number of specific recommendations relating to tuberculosis were given).

3. Multi-phasic Screening

(a) Multi-phasic screening procedures should only be used where the test validity and acceptability have been evaluated on an experimental basis and for cost effectiveness.

4. Staff Utilization

(a) More appropriate utulization of staff-i.e. lesser qualified person at a lower dollar cost performing task now performed by specialized professional person.

(b) Operational practices incorporating labour saving devices be instituted where feasible.

(c) Organizational and administrative procedures be designed to afford more effective control-i.e. buying service in relation to need, free senior professional staff of routine administrative duties, unification of community health services.

(d) Legislation be made flexible to permit alterations in the allocation of duties and responsibilities of personnel in local health departments.

5. Voluntary Agencies

Voluntary agencies have a vital role and should be encouraged; their delivery function should be integrated with the overall Health-Care Program.

6. Statistics

Current statistics inadequate to assess current community health practices fully. Effective evaluation or cost of programs limited by limitations of data. Specific recommendations were made relating to improving statistical data base.

17. Task Force Reports on the Cost of Health Services in Canada. Committee on Costs of Health Services. Vol. 1-3, 1969.

Health is a labour-intensive industry - 70 percent of health costs are fees, salaries and wages. Therefore it is necessary to ensure maximum productivity. Economy in the health services must be encouraged. Regional organization of all health services, involving central co-ordination of many facilities and agencies is essential to cost efficiency. Understanding and co-operation by the consumers is a necessity.

The recommendations deal with 16 areas.

(1) Co-ordinated government planning e.g. each Province should have an overall program of health care delivery.

(2) Regionalization-e.g. organization of regional health planning.

(3) Utilization of hospital and physician services-e.g. development of mandatory conditions for all elective admissions; development of norms or standards for the use of hospital treatment and diagnostic services.

(4) Planning hospital facilities-e.g. lower priority to acute in-patient facilities and upgrading, replacing or remedying role of alternative services.

(5) Teaching facilities-e.g. facilities should not be built unnecessarily as solution for University teaching problems.

(6) Operational efficiency - e.g. work studies be done to determine maximum efficiency.

(7) Financial incentives and analyses-e.g. use of incentives should be encouraged and supported as means of stimulating greater productivity.

(8) Manpower utilization - e.g. activities should be appropriate to level of preparation of practitioner-i.e. operating room technicians rather than registered nurses.

(9) Patient care classification-e.g. patient cared for at level which is best suited to his needs and which is most economical.

(10) Standards of patient care - e.g. guidelines be created to help determine criteria for admission, investigation, length of stay, etc.

Task Force Reports Cont'd.

Recommendations

(11) Ambulatory Services-e.g. provision of full range of diagnostic and treatment services.

(12) Home Care-e.g. home care programs should be expanded.

(13) Health Care Administration-e.g. government should experiment with capitation method of payment.

(14) Fee Schedules-e.g. accurate, up-to-date information on average net incomes of physicians in full-time practice in various locations, be used to develop rational fee schedule.

(15) Mass screening-e.g. mass screening programs should meet specific criteria prior to receiving support from public funds.

(16) Education-e.g. specialized training programs should be established and financed-i.e. "practitioner-associates, dental auxiliaries, clinical specialists"; training in health economics be included in curricula.

18. Detailed recommendations from the Task Force Reports on the Cost of Health Services in Canada. (Summary). Vol. 1-3. 1969.

1. Co-ordinated Government Planning

Recommendations

(i) Administrative arrangements should be made to provide full co-ordination of the total health care delivery system at the Provincial level, with health services, welfare services, mental health care, hospital care, and medical and ancillary care as elements - - - - and overall plan. Greater emphasis should be placed on defining the needs of elderly, low-income, and other disadvantaged groups, and on evaluating the programs now directed at these groups, in order to achieve a judicious allocation of resources in relation to anticipated results.

Hospital salaries and medical fees are two main elements in health care costs.

(ii) Governments should provide continuing expert consultative research and advisory services to both hospital management and unions, to improve collective bargaining systems and dispute settlement procedures, and thus achieve better services to patients combined with maintenance of the rights of social justice of health workers: - - - make available to medical associations full data regarding frequency and costs of medical services and ranges of gross and net payments to doctors according to speciality and region to aid them in the development of rational fee schedules. Government agencies and medical associations should discuss and agree upon the total percentage change in physicians' net incomes that should be achieved by a new fee schedule before the schedule is revised.

The development of guidelines for standardized immunization procedures with possible reduction in the numbers of booster shots and small dosage, and the carrying out of immunization procedures by public health nurses, would be significant to cost control.

(iii) Communicable disease control programs should be developed particularly through aggressive planning and operation of immunization activities. Immunization procedures generally should be carried out by public health nurses under physician supervision in public health agencies. Immunization procedures should be standardized within each Province by the preparation of guidelines for medical health officers as to what is an adequate level of immunization, including the possibility of using smaller doses of vaccine and reduced number of booster shots.

2. <u>Regionalization</u>

Regional planning for health facilities and services is required for achievement of an integrated and balanced health care system. Essential that there be an overall program of health care delivery.

The organization of regional health planning boards should be encouraged. Boards should be composed of representatives of hospitals, other health and welfare agencies, medical profession and other appropriate groups.

Boards - advisory capacity to Provincial authorities - - responsibilities and functions would be:

(a) Continuing planning and development of a regionalized, comprehensive, integrated and balanced health care system of services and facilities within the context of the regions spectrum of health services.

(b) Research or Studies - determine actual needs and how they can be resolved in most effective and efficient manner.

(c) Improvement of communications between agencies, fostering of effective co-ordination of health services within the region, definition and clarification of each hospital and the services it would provide.

(ii) No changes in physical facilities or services which significantly affects the nature of any health care institution or service, without the prior review and recommendation of the regional board. (Responsibility for recommending new and expanded facilities, conversion to alternate use or closure of facilities).

(iii) As first step - - - regional hospital boards should be set up. Regional hospital boards have executive authority granted by the Provincial authority on specific activities such as:
(a) the grouping of hospital services;
(b) group purchasing of supplies or services.

Medical profession must be directly involved, if regional planning is to work.

(1) Medical involvement in regional planning should be accompanied through such mechanisms as representation on the regional board and establishment of representative and responsible regional medical staff groups advisory to the regional board.

3. Utilization

A. Efficient utilization of hospital and physician services is a major element in controlling health costs. Admission to a hospital is costly and ways of improving the utilization of hospital in-patient facilities need to be ensured.

Control of Admissions: Recommendation

For all elective admissions, a history, a description of pertinent physical findings, and a statement of the proposed diagnostic and treatment regime, should all be presented to the hospital prior to the admission of the patient. This should be a mandatory condition of admission for the elective case. Where possible, a note of previous pertinent investigative results should be supplied. With regard to genuine emergency admissions, it should be mandatory that such a record be placed on the chart within twelve hours. The implementation of these proposed mandatory conditions for admission of a patient should be the responsibility of the hospital administrator.

Implementation would require alterations in Provincial legislation, understanding and support of the medical profession; maintenance by the hospital of a first class records department and necessary amendments to hospital by-laws to give authority and direction to the administrator and utilization committee; and education of the public.

B. The use of hospital services is an outcome of physician decision-making. Criteria or norms for the use of hospital diagnostic and treatment services need to be developed.

Control of diagnostic and treatment services

(1) The medical staff should develop norms or standards for the use of hospital treatment and diagnostic services, particularly in the admission, investigation, length of stay and discharge areas. Once developed by the medical staff, an appropriate medical staff committee, with the assistance of the hospital administration, should be given the responsibility for applying them.

Implementation would require the setting up of committees to develop norms or standards for given hospitals or regions and the co-operation of hospital medical staff.

(ii) A utilization committee should be mandatory in hospitals with a medical staff organization to regulate practitioner access to diagnostic services, control new techniques and new procedures, control informal research and regularly review routine orders. The Directors of diagnostic departments should be given authority to carry out the policy laid down by the utilization committee within their departments.

C. Discharge or transfer of Patients

Discharge or transfer to other levels of care, at the appropriate time, is required if patients are to stay in acute treatment beds no longer than necessary. Discharge or transfer of the patient should be planned in advance.

Recommendation

All hospitals should have a discharge planning activity. The discharge planning group should have medical leadership, and representation from community health agencies should be invited. In hospitals of more than 200 beds, the person in charge of the discharge planning groups operation should be a social service worker, a nurse, or similar qualified person, interested in this type of activity.

D. Control of Physician/Patient Abuse of Services

Statistical methods used in the past to measure servicing or utilization patterns have produced infrequent cases of abuse, but knowledge that regular reviews are being conducted may have a restraining influence on costs.

Recommendations

Medical care plans should appoint medical review committees of practicing physicians to initiate continuing studies of the patterns of practice of all physicians. These studies should also be used to identify excessive use of laboratories and other diagnostic services. On the recommendation of the Provincial Medical Association, government medical care plans must be prepared to impose financial penalties on physicians where it has been demonstrated that they have been guilty of over-use or abuse. The plan should also take steps when it is shown that members of the public are similarly guilty in requesting physician services.

Implementation would require legislation necessary to establish review committees where necessary; committees composed of physicians knowledgeable about patterns of practice in their own geographical areas and medical fields; profile data, recommendations from the committees to the medical care plan and information from the plan to the hospital plan.

4. Planning Hospital Facilities

Past priority has been given to general hospital and acute treatment facilities and there is a disproportionate number of beds available for acute care as opposed to extended or chronic care. The planning and development of specialized services need to ensure reasonable deployment of facilities according to the geographic characteristics of the area; maintenance of adequate standards of staffing in terms of current practice, and an organization of services in a manner to ensure maintenance of high standards and efficient use of highly specialized personnel and facilities.

Recommendations

(1) The only occasion for considering a hospital of less than 75 to 100 beds is where travel time to a community hospital exceeds one and one-half hours; a small hospital might be considered for an area with 5,000 to 6,000 population, which might be expected to attract a minimum of two and preferably three physicians. Such a facility would be expected to send out a significant proportion of its cases to a larger centre leaving a local need of about 30 beds.

(ii) In general, planning should give lower priority to additional acute in-patient facilities than to upgrading, replacing or remedying the deficit elements in the system such as ambulatory care, diagnostic facilities, community health centres or long-term institutional facilities. Criteria for adding new acute beds should be:
- (a) inadequacy of present supply to meet existing measurable demand; or
- (b) No capacity to meet present demand projected for a predicted population five years hence.

Additional exceptions should also be made for new acute construction that will not expand total bed supply, e.g., replacement of condemned facilities, extension in one community to serve another where small hospitals are being closed, and for remodelling. In both cases it should be demonstrated that the new construction or remodelling will:
- (a) meet an existing service need,
- (b) improve quality in some way that can be measured, or
- (c) deliver medical care at a lower cost than before.

(iii) Burn Units - these should be restricted to major Metropolitan areas;
Coronary Care Units - hospitals should meet the following requirements:
- (a) staff must be specially trained and experienced;
- (b) coverage by staff must be adequate;

(c) after establishing a formula, the beds required for given cases can be estimated. Hospitals with a work load requiring less than two beds should consider the development of a joint coronary care-intensive care unit. A figure of two beds constitutes a full work load for a specially trained nurse on a 24-hour basis.

Intensive care unit - a formula of 3-4% of the medical and surgical beds as representing the intensive care requirement of the hospital should be used. Hospitals with a work load requiring less than two beds should consider the development of a joint intensive care - coronary care unit. Cardiac surgical facilities should be restricted to the major teaching centres. It is not likely that a region with less than 500,000 population would generate the required minimum work load. Only an area of more than one million population might justify the use of more than one such unit.

Radioisotope facilities - therapeutic radioisotope services and other diagnostic services involving patient scanning should be limited to hospitals serving major geographic areas when:

(a) need for good care makes a unit necessary;
(b) adequately trained staff are available.

In other hospitals, diagnostic services involving small quantities of radioactive material of low toxicity and simple counting devices should be considered when these procedures constitute an economically sound alternative to the more conventional laboratory procedures.

Dialysis centres - it is recommended that dialysis centres be established in hospitals and Metropolitan areas where the caseload can justify an active nephrology service. Such centres should be related in all instances to a renal transplantation centre in a major Metropolitan area.

Implementation of the above recommendations require that Provincial governments, and regional and area planning councils, take an active and firm stand in determining and enforcing criteria which should be utilized in any particular situation.

(iv) Specialized emergency facilities and services, particularly in urban areas, should not be distributed among all hospitals in that area. One institution (in larger cities more than one), should be designated as the emergency centre for the area. This centralized emergency service would be staffed with highly qualified people with the necessary sophisticated equipment, and would be able to offer a truly comprehensive emergency service.

Implementation requires that definitive guidelines be established, co-operation of the medical profession and education of the public regarding appropriate use of emergency facilities.

5. Teaching Facilities

There is evidence of over-bedding and duplication of facilities to meet university requirements for teaching.

Recommendation

Planning for university teaching facilities should be reviewed by the regional planning body, to ensure that facilities are not being built unnecessarily. Universities should demonstrate the impossibility of using existing facilities for teaching purposes. The Federal and Provincial Governments should give joint consideration to the need to ensure that, where highly developed teaching and research facilities exist, they should be used by other medical teaching units whenever practical, rather than duplicating the same level across the nation.

6. Operational Efficiency (Hospitals)

Evidence indicates that effective productivity could be improved by 10-30%; nursing resources need to be managed more effectively; and there is a need for group purchasing and centralization of services such as laundry, and the scheduling and optimum utilization of diagnostic services.

Recommendations

(i) Groups of work study personnel should be established in each Province to carry out work studies in hospitals and to insure that approved recommendations are implemented.

(ii) Nursing care should be planned on the basis of an analysis of the individual patient's needs, not on "routine" or traditional practices. This would tend to eliminate activities done on a ritualistic basis, save nursing care time, and lend to more equitable staffing on days and nights. Nursing units should not be staffed for the maximum nursing care load. Additional personnel should be employed as required to take care of an increased nursing care load.

Admitting policies and procedures should be reviewed and changed to provide for more equitable distribution of patients to nursing units, based upon available resources in the unit.

(iii) Hospitals, on a regional or provincial basis, should adopt, through group action, standard linen material and size to facilitate the manufacture and distribution of linen supplies .

Centralized purchasing and the feasibility of central laundries should be studied by groups of hospitals on an area basis.

(iv) Provincial and Federal authorities should support fully the Task Force's recommendation regarding the "principal purchasing method" as it pertains to "value analysis".

Provincial authorities should urge hospitals to prepare once a year an Inventory Cost Calculation, which should include at least:
(a) the purchase cost (quantity in dollar value carried times 20-25% or any other accepted percentage).

This cost calculation may have to be broken down in major supply items and compared to previous experience and budgets, and could become a routine requirement on an annual basis. Furthermore, the hospitals should be urged to increase annual joint contractual buying with bidding procedure and drop shipments.

(v) That hospitals be charged with the development of a diagnostic services scheduling program so that there will be no undue delays.

(vi) Group purchasing techniques in the pharmaceutical area should be immediately introduced Province-wide for care drugs because:
  (a) Drug prices would at least be reduced to the level of the hospital which pays the lowest price;
  (b) Volume orders for a limited number of expensive drugs may yield savings of 30% or more.

7. Financial Incentives and Analysis

Effective productivity rates may be reached and maintained through the use of incentives for hospitals and their employees. Under the present hospital insurance plan the hospitals have no financial encouragement to reduce costs. Capital funds are needed for replacing existing equipment or acquiring new equipment which would improve efficiency and reduce labour and/or operating costs. Costs related to education, medical components and research need to be separated out from actual cost of care.

Recommendations:

(i) Provincial and Federal Health authorities should encourage and support incentives to stimulate greater productivity in hospitals at both departmental and staff levels. A portion of the operating savings, which are achieved by cost being less than normal acceptable standard costs, should be retained by the hospital. It would be free to use these funds for any purpose which its board might approve.

(ii) Incentives should be provided to encourage joint ownership and operation of such facilities as laundries, laboratories, radiology facilities, computer services, pharmacy and dietary services.

(iii) Capital funds should be provided when it can be demonstrated that operating savings will result from the use of new or improved equipment, which could be amortized over three to seven years. An incentive plan should be established so at least part of the savings could be retained by hospitals after the amortization period.

(iv) Capital expenditures for non-shareable equipment should be provided where it can be proven that the cost will be offset by operating savings. After capital cost amortization, a portion of the savings should be retained by the hospital.

(v) The fee charged for each laboratory or radiology service should be allocated on a cost basis of the three components, professional services-overhead-capital investment, whether the service is performed in a public or a private facility.

(vi) The Canadian Hospital Association should be asked to develop on a uniform basis an extension of their Canadian Hospital Manual, to delineate expenditures made by hospitals on patient care, medical component, education and research. Hospitals should be reimbursed in a way which separates the cost of patient care from the cost of education and medical components.

8. Manpower Utilization

The importance of more efficient use of registered nurses should be underlined.

Recommendation

Registered nurses are not required and should not be employed in central sterile supply departments, admitting office, pharmacy, etc. Should a hospital continue to employ nurses in these areas, these nurses should be on the staff of that department, not of the nursing service department, and should be paid accordingly. The number of registered nurses in operating rooms should be reduced and operating room technicians employed instead.

All hospitals should be encouraged to adopt at the earliest possible time a program for assessing patient needs on a day-to-day basis and adjusting staffing patterns in nursing units accordingly.

All immunization procedures generally should be carried out by public nurses under physician supervision.

The public health nurse should be trained to give routine immunizations, to recognize contraindications and sensitivity reaction, and to give the necessary treatment. Instructional material should be made available to her.

8. Patient Care Classification

The needs of patients vary considerably and these needs must be recognized on an individual basis. The right treatment in the right institution by the right staff will mean a more rational and economical use of personnel and facilities.

Recommendation

(1) The patient should be cared for at the level which is best suited to his needs and which is most economical. This involves a range of care, acute, chronic, convalescent and intermediate hospitals, boarding homes, care in the patient's own home, and ambulatory care. All agencies should adopt programs for assessing patient needs on a day-to-day basis and staffing patterns should be adjusted accordingly. A uniform classification of care functions should be developed and used throughout Canada.

10. Standards of Patient Care

New technology, information and greater personnel resources are resulting in changing patient care standards, and mechanisms need to be created to ensure application of the best standards of patient care.

Recommendation

(1) Guidelines should be created to help determine the criteria for admission, investigation, length of stay, discharge, and the establishment of specialized services for coronary care, burn units, etc. to ensure both the best use of the resource and the quality of service.

11. Ambulatory Services

Increased use of hospital out-patient facilities for a number of services including minor surgery would decrease demand for acute beds and reduce hospital operating costs.

Recommendation

(i) A full range of out-patient diagnostic and treatment services should be ensured in every Province.

(ii) Impetus should be given to the development of a broad range of ambulatory services, permitting a reduction in the ratio of active treatment beds that a community or region would otherwise require.

(iii) First priority should be given to establishing community health centres containing a full range of preventive, diagnostic and curative services - but no beds for overnight care. Such centres may be operated as branches or satellites of established general hospitals.

12. Home Care

Community-based home care programs are a means of providing many health services more economically.

Recommendation

Home care programs should be expanded to become a significant component of the health care system for use when:
(1) medically indicated as a form of treatment;
(2) treatment cost can be demonstrated to be lower than the same treatment provided in hospital;
(3) beds are in short supply and are required for patients who cannot be served by alternative means.

13. Health Care Administration

Recommendations

(1) Government medical care insurance plans should be prepared to experiment with the capitation method of payment, particularly where this is desired.

(11) The level of support offered to the physician outside the hospital should be developed so that he will be encouraged to use such services where medically appropriate, and where no additional work load for himself or cost to the patient is involved.

Implementation of the latter recommendation would require extension of insurance plan benefits to include supporting services outside the hospital.

14. Fee Schedule

A. Fees

Physicians' fees make up a large portion of the overall costs of medical care. Information is required for determining the fiscal effects of revisions on the earnings of a particular type of physician.

Recommendation

(1) Accurate, up-to-date, information on the average net incomes of physicians in full time practice (general practitioners and all types of specialists) in various locations in each Province must be used to develop rational fee schedules. This information has not been available in the past. Government-sponsored Provincial plans should make available to medical associations full data regarding frequency and costs of medical services, and ranges of gross payments to (or on behalf of) doctors in the various specialities and geographic areas.

Data on gross and net income and expenses of practice should continue to be gathered and analyzed by the Department of National Revenue and the Department of National Health and Welfare, and should be adjusted by considering the doctor-population ratio in various specialities and Provinces, and also by taking into consideration geographic peculiarities of the Province.

Fee schedules should be revised at intervals of about three years, in order to keep physicians' net incomes in line with the general economy, and to adjust for changes in patterns of practice and changes in overhead expenses. Before each revision is undertaken, the total percentage change in physicians' net incomes which the new schedule should bring about should be discussed, and if possible, agreed upon by the Provincial Medical Association and the insuring agencies. These would be net incomes before the payment of income tax.

Once fee schedules and overall costs of physicians' services have reached an acceptable level, further changes should be based upon agreed economic indices, so that fees and costs move in proportion to the economy of the country or Province. Various weightings of the consumer price index and the index of average weekly wages and salaries have been suggested, but further study is required to find the most appropriate formula. The effects of the application of any formula must be examined regularly.

B. Physician use of Hospital out-patient facilities.

Physicians often use out-patient hospital facilities for procedures which are normally carried out in their private offices.

Physician use of Hospital out-patient facilities con'td.

This practice increases hospital costs, because additional personnel, space, equipment and supplies are required to provide the service. Rarely are physicians charged for the use of out-patient facilities.

Recommendation

Provincial medical fee schedules for procedures normally carried out in the physician's office should be developed on a two-value basis:
(a) when carried out in a private office;
(b) when carried out in hospital facilities.

Realistic fee schedules should be charged by hospitals for ambulatory care. In Provinces in which no hospital charge is made to patients for out-patient or emergency services, the Government payment formula should include a realistic factor to cover these costs.

Each Province should develop policies and cost sharing formulae providing for rental payments by doctors for offices and other accommodation in hospitals used for the practice of medicine.

C. Use of Allied Health Workers

Physicians perform many routine duties which can just as ably be performed by other, less highly paid, professionals.

Recommendation

(1) The medical care plan should cover the services of allied health professionals working under the direction of practicing physicians. Payment for services should be appropriate to the status of the person rendering the services, and to the costs involved.

Implementation may require changes in the regulations under Medical Acts; physicians would need to accept the role of allied health care workers and assist in their training and orientation within the health team, and the general public must be made aware of the proper use of allied health professionals.

D. Remuneration for diagnostic procedures

Technological advances in diagnostic procedures, and equipment required to carry out these procedures, requires that a constant review be done to determine the methods and levels of remuneration to physicians.

Recommendation

Many laboratory procedures can be done in different ways at varying levels of cost. New high-volume and "instant methods" of performing tests with automated equipment carry a lower cost-per-test than than traditional manual methods. Fees charged and payments made should be related to the method used. It should be noted that automated laboratory equipment is expensive and must be funded. In rendering of services by a laboratory and in radiology, there are three elements to be considered. These are:

(a) the professional components;
(b) the overhead, including salaries of staff; and
(c) the capital investment.

In determining fees for services in this context these three elements should be separately considered. This applies to both public and private establishments.

15. Mass Screening

Mass screening refers to the administration of a test or tests to a population, generally from a total community, consisting largely of normal persons or persons without signs or symptoms, for the purpose of identifying the likely presence of a single disease state at an earlier stage in time than is customary. Mass screening should be viewed with caution.

Recommendation

(1) Mass screening for disease in the undiagnosed state should not receive support from public funds unless such screening is:
(a) selective as to methods used, considering their sensitivity, specificity, cost efficiency, and cost effectiveness in terms of meaningful intervention in the natural history of disease;
(b) directed to high risk groups including those which do not customary seek medical care; and
(c) followed by a diagnosis with a minimum loss to follow-up of positive screenees.

Further evaluation of multiphasic screening should be undertaken to establish the validity of this approach in clinical practice, prior to any mass applications supported by public funds.

16. Education

Education of key personnel may result in long-saving improvement of resource allocation and administration in the field of health care.

Recommendations

(1) Current degree programs in hospital, health and nursing administration should be improved and updated by emphasizing modern management techniques and principles. The number of basic and continuing education programs in health administration at universities, community colleges and applied arts and sciences institutes should be increased.

(2) Medical school curricula should include training in the economics of health care, and place greater emphasis on clinical medicine in diagnosing disease, including the requirement that any test ordered be justified on rational grounds.

(3) Specialized training programs should be established and financed:

(a) to train on a pilot project basis a class of "practitioner-associates" in a university teaching unit under medical direction;

(b) to train "dental auxiliaries" to assume certain functions now carried by dentists;

(c) to train "clinical specialists" in nursing at graduate and post-basic levels.

18. The Ontario Committee on Taxation Report 1967
Vol. 1-111. 1967 (Smith Report).

Chapter 38

I. Discussion: Acute care hospitals not being appropriately used - (1) patients who could be treated and/or maintained in less costly facilities such as nursing homes now occupy "costly" hospital beds. (2) no financial incentive to patients or hospitals to transfer to less costly facilities - e.g. elderly patient sustains loss of pension upon transfer to nursing home.
Consideration should be given to ways of encouraging the use of convalescent centres, etc. Assistance to needy or extension of insurance coverage may be necessary.

Need to increase public awareness of costs of hospital care. Premium payment regressive for lower income group. It does provide means of relating payments to benefits received. No alternative to combination of public and private financing.

Recommendation: 38.8 Premium rates for Hospital Care Insurance Plan be maintained at a level to yield roughly one-third of the total financial resources required to meet operating costs.

38.10 When future changes in premium levels become necessary consideration be given to incorporating into the Hospital Care Insurance Plan a scheme of subsidized premiums comparable to that in the Ontario Medical Services Insurance Plan.

Direct patient charges should be examined if experience with utilization or with abuses indicate that additional procedures are warranted. A system in which benefits have no prescribed limit is open to abuse from those seeking to maximize benefits.

On discharge from hospital, patient should be given a receipted hospital invoice showing the cost of services rendered. This activity should increase patient awareness of actual costs and extent to which hospital care is subsidized.

Chapter 23

Regional Government would facilitate more economical and effective public health units and hospital facilities.

Rationale:

(1) Modern hospital cannot be used efficiently if serving small population.

(2) Division of labour would be facilitated among hospitals as far as expensive equipment and specialized services are concerned.

(3) Centralization of hospital services would be possible.

(4) Planning and financing expansion in the context of overall priorities and requirements would be facilitated.

19. Taxation in Ontario: A Program for Reform: The Report of The Select Committee of The Legislature on The Report of the Ontario Committee on Taxation. (White Report).

I Rationale: Maintain and/or increase public awareness of actual costs. An indirect means of controlling costs.

Recommendation: 38.8 of Smith Report accepted. Premium rates for Hospital Care Insurance Plan be maintained at a level to yield roughly one-third of the total financial resources required to meet operating costs. (Page 450 of Smith Report).

Dissensions: Premiums are regressive form of taxation and should be kept to a minimum. More progressive form of taxation should be used for balance of hospital costs.

II Rationale: Hospital care should be available to those who need it, regardless of ability to pay. Some individuals will not be in position to pay premiums.

Recommendation: 38.10 When future changes in premium levels become necessary, consideration be given to incorporating into the Hospital Care Insurance Plan a scheme of subsidized premiums comparable to that in the Ontario Medical Services Insurance Plan.

Dissension: Direct tax method such as used in financing Canada Pension Plan would make the taxpayer clearly aware of the costs. If income not taxable, no premiums. Maximum amount of taxation to be established.

20. Evans, R.G. and Williamson, M.F. Extending Canadian Health Insurance: Options for Pharmacare and Denticare. Ontario Economic Council Research Studies. 1978.

Estimated costs of Universal insurance program for Pharmacare and Denticare, based on 1975 dollar costs and population and most probable ranges of utilization responses are $280.4 - $318.6 million for Pharmacare and $392.7 - $458.1 million for Denticare.

Four objectives guide the formulation of public policy with reference to insurance programs.

1. Reduction of risk of financial loss by potential users.
   Both Denticare and Pharmacare would reduce risk of large expenditures, but for most of the population the risk is small or non-existent. Risk-reducing benefits of Pharmacare apply only to a small and easily identifiable part of the population, that is the elderly and chronically ill. The risk-reducing benefits of Denticare are virtually non-existent.

2. Redistribution of wealth from low users to high users.
   Pharmacare would benefit the elderly and chronically ill, a small and easily identifiable group. Denticare would likely result in distribution from lower to higher income groups, unless some mechanisms were found to increase overall utilization which would lead to increased costs. (Dental Care is highly associated with socio-economic class). Supply constraints associated with increased utilization would likely effect the present non-users and reinforce the distribution from poor-to-rich.

3. Reduction in barriers to care which would lead to increased utilization and thus lead to better health.
   (a) Pharmacare - increased utilization levels would likely have a negative effect on health.
   (b) Denticare - utilization does have a positive benefit on health, but impact of insurance on those who are not regular users of dental care is weak. In addition, evidence indicates that dentists tend to overservice existing patients in presence of insurance. Overservicing would have weak and possibly negative effect on health.

4. Promotion of efficiency in delivery of services.
   Introduction of Universal insurance would have unambigious negative effects. Present competition incentives to increase efficiency would be removed. The "freezing" in place the existing delivery system would remove opportunity for significant productivity increase such as could occur with extension delegation of tasks to auxiliaries.

Conclusion: The potential benefits of Pharmacare and Denticare programs are small and costs would probably outweigh benefits. Partial insurance plans appear to be superior to Universal plans. Three alternatives to Universal Pharmacare are:

(1) Pharmaceutical insurance program for over-65 population; would have the wealth transfer and risk-reduction benefits of a Universal plan while avoiding most of the utilization and efficiency costs.

(2) Universal program with deductible of either $50 or $75; would reduce subsidy to aged, alert users to prices, and contains potential for maintaining competitive pressures on suppliers.

(3) A public program to rational the dispensing and wholesaling process e.g. similar to Saskatchewan program - Government enters wholesaling, either directly or through private agents, to bid down drug manufacturer's supply prices through bulk buying. Drugs are then supplied free to the retail level and thence to the patient. The patient pays a dispensing fee set independently and advertised by the pharmacist, - maintains and strengthens efficiency - promoting incentives. A deductible plan could be included, further protection against high expenditures.

Alternatives to Universal Denticare to be considered are:

1. Public Dental Insurance for children aged 3 - 17. A School-based public delivery system, built around dental nurses or therapists, would attain utilization levels of 90% of an estimated cost of $81.2 - 87.5. High utilization would be necessary to achieving an improvement in dental health and in preventing programs from acting as wealth transfer from low to higher income groups. All experience shows that a 90% utilization level cannot be achieved in a private practice-based plan.

2. Universal program of extensive auxiliary use in adult and child dentistry, competitive forces to adjust dental fees - potential unit price reductions. Extensive use of auxiliaries is estimated to have a potential reduction in unit costs of dental care of 30-40%. Universal insurance under such a system of dental care delivery is estimated to be $384.8 - 449.0 million contrasted with the $641.4 million under current modes of delivery. Difficulty lies in changing mode of delivery and ensuring that benefits are passed to the consumer in form of lower costs.

   Conclusion is that optimal policy is definitely not to introduce a Universal Dental Insurance program, as such a policy would ensure that potential transformations of dentistry do not occur.

<u>Reasons for Expansion of Private Dental Insurance</u>

1. Individuals may purchase dental insurance because of ignorance or irrationality in a broad sense; purchase made on imperfect knowledge about expected loss, amount of expected loss reimbursed and the true price of coverage. Most members pay more in premiums than they receive in benefits.

Reasons for Expansion of Private Dental Insurance cont'd.

2. Belief of employees that coverage paid by employers are free to the employee. Obvious trade-off of fringe benefits against salary often ignored.

3. Group purchase level:
   (a) response to tax inducements, that is, unions may negotiate over insurance rather than direct salary in order to maximize its members' after-tax benefits;
   (b) preferences of members with respect to direct wages or employer-paid fringe benefits e.g. high users may pressure for dental insurance which will provide means of obtaining subsidies from low users.

Over-insurance tends to perpetuate a very high-cost mode of providing dental services and makes it more difficult to change mode of delivery.

21. Let Us Take Care. A Report to the People of Ontario. Ontario Nurses' Association. 1977.

A. Facilities for Chronic Care

There are inadequate facilities for patients requiring alternatives to active treatment beds. A major problem is the lack of co-ordination and planning between the various levels of government involved in providing and financing services.

Recommendations relative to cost containment

1. All areas of the Province should develop registries of available nursing homes for the aged beds. There should be assessment and placement services for these beds which would be run by a co-ordinating body in the area.

2. In areas where there aren't enough nursing beds, but where the elderly population requiring nursing home services does not warrant the construction of extra facilities, the Ministry should re-evaluate the use and function of beds in the hospitals, so that beds used by long term chronic patients could be assessed at a lower cost.

3. Re-organize present facilities to accommodate present needs-i.e. where there is need demonstrated for nursing home and extended care facilities, and where, because of an excess of active treatment beds, wards and units have been closed, that every effort be made to convert these wards to chronic and extended care wards, and to designate them and fund them accordingly.

4. The Ministry should increase its funding to community support programs for the elderly, so that as many people as possible can be maintained in their own homes. Only after this is done, should they assess the need for, and supply of, nursing homes and homes for the aged beds.

5. There should be steps taken to integrate programs and services for the elderly under one Ministry.

B. Misuse of Hospital Services

Hospital facilities are misused. Services in doctors' offices are normally available for somewhat less than 25% of the hours in a year. At other times, people with medical problems seek help at the emergency departments of hospitals. There is misuse of hospital services and beds.

Recommendations

1. Community health centres be established to provide ambulatory care and screening to limit the misuse of hospital emergency units by non-emergency cases, combined with education of the public to utilize these less-costly but equally effective means of care.

B. Misuse of Hospital Services/Recommendations

2. Committees be established within hospitals to control overuse of emergency units by doctors who send their patients to the emergency unit, rather than see patients in their own offices.

3. Effective admission and discharge committees be established, co-ordinated by a nurse with public health background, which would control bed use and utilize all available community services.

C. Wastage within Hospitals

Wastage, mismanagement and poor planning still occurs in hospitals-i.e. hospital three years old but already major reconstruction occurring.

(No specific recommendations were made).

D. Co-ordination of Services

The need for co-ordination of health care services is recognized.

Recommendations

1. That the government immediately establish and empower district health councils in all areas of the Province where councils do not exist - including areas where the medical profession and others have pressured against the establishment of councils.

2. That organized groups in the community, including unions working in health care settings, be encouraged to submit nominations to the district health councils, for the council itself, and its sub-committees.

3. That a formal method of consultation with, and involvement of employee groups in, decisions around planning for health services be established by the councils.

4. That council meeting be well advertised and open to the community, and that councils hold public meetings once a year to report on their progress and recommendations.

5. That employee groups in hospitals and other health facilities be aware of, and involved in, budgetary discussions and program planning meetings.

E. Medical Manpower Substitution

There are no incentives for physicians to use other health personnel to provide care. The system encourages doctors to provide many services which could be provided by other skilled workers. Nurse practitioner programs were funded by National Health and Welfare for four years. The Ontario Ministry of Health is not picking up the funding when the National Health and Welfare funds are discontinued.

The use of community health centres is another less costly way of providing high quality care.

Recommendations

1. That the government carry on the funding of nurse practitioner courses in the Province, as well as make provisions for the continuing education and upgrading of public health nurses, to enlarge their competence and scope of practice.

2. That the government ensure that nurse practitioners be fully utilized by clinics and physician medical practices, by amendments to fee schedules to provide for payment for nurse practitioners' services.

3. That the government fully fund community health centres which presently exist, as well as allow for the development and funding of other centres throughout the Province.

F. Home Care Services

Services such as home care programs have great potential within them to decrease stay in hospital beds. Inadequate funding and lack of linkages among services pose problems.

Recommendations

1. That there be increased funding of the home care program, and establishment of long term home care programs throughout the Province.

2. That hospitals include in their staff inservice program education about community health and social services programs and facilities.

3. That there be implementation of effective hospital admission and discharge planning committees, with the involvement of both home care and public health personnel in discharge planning.

4. That there be an amalgamation of present community nursing services - developed, directed and co-ordinated by nurses, with 100% funding by government.

5. That the government provide for utilization of public health nurses as attachments to physician practices and clinics.

6. That there be co-ordination of health and social services at the municipal level, possibly through the use of community health centres, with the services of doctors and nurses available on a 24-hour basis.

7. That present community services be expanded to provide home care and public health services on a 24-hour, seven day-a-week basis.

Home Care Recommendations cont'd.

8. That strong financial support be provided for community social services, such as meals-on-wheels and homemakers.

G. Use of Public Health Nurses

The emphasis on care, rather than prevention, has contributed to resource allocation being misdirected. Public health nurses are prepared to conduct preschool health assessment, but in some areas are prevented from performing this activity. The public health nurse's role in health education, well-baby clinics, and immunization has been curtailed in many areas of the Province. Pressure from medical profession has been a decisive factor.

Recommendation

1. That educational programs be established for members of Boards of Health regarding the role of health unit employees. This program be the responsibility of the Ministry of Health.

2. That public health nurses be involved in decisions regarding what programs are implemented by the health unit.

3. That information regarding all aspects of health unit work be available to the public; the budget, how the money is spent, and meetings be open and advertised.

4. That public education programs be implemented regarding health requirements and how they can be met, as well as what programs are available in the community and where to find them.

5. That Boards of Health be elected from public at large.

6. That the Province define mandatory programs, such as well-baby clinics, immunization clinics, preschool and other assessment and screening programs - which units must carry out - so programs are not left to the whim of local politicians.

7. That there be co-ordination and communication between Federal and Local Public Health Services regarding health programs for the native population.

Nursing Workloads (in Hospitals)

Changes have occurred in workload of nurses in Acute Care Hospitals. There have been reduction in nursing staff, support services-i.e. dietary, housekeeping, and changes in patient population-i.e. more acutely ill patients.

Recommendations

1. That the Government commission and finance a comprehensive study into manpower and productivity in nursing services - an area that has not been explored, documented, nor had guidelines developed within the Health Services of Ontario.

2. That the Government seek out the professional nursing organization - RNAO - to undertake such a study. This study to develop guidelines for preparation, utilization and productivity of manpower in nursing services with realistic staffing patterns, according to the needs of the consumer as, well as providing for continuing education, including orientation periods for new staff.

3. That health agencies involve nurses in planning staffing needs, new services or programs as well as reduction, redistribution or deletion of present services/programs that affect nurses.

22. Ontario Public Health. Some Current Issues. 1977. Ontario Ministry of Health.

This report contains a summary of major problems identified in the public health system, and a number of recommended policy adjustments. Major problems are:

(1) Health professionals encountering difficulty in meeting the range of emerging demands, due to a lack of resources and/or mandate needed to do the job. Demands will increase due to constraints on other organizations; changing policies of other parts of the health and social services network-e.g. de-institutionalization, and increasing interest ensuring the health of the public,-e.g. life-style programs;

(2) Lack of understanding of the relationships and linkages of the public health system to the other systems within the health services field and to other related systems;

(3) Serious management and organizational problems within the public health system.

Recommendations:

(1) The Ministry ensure the development and implementation of a comprehensive policy and co-ordinated program for health promotion; the development and testing of effective methodologies related to ongoing and newly initiated efforts in health promotion; that health promotion actively focus on areas of greatest requirement; and the partnership in the planning, development and design of major health promotional activity among Provincial and local agencies.

(2) The Minister of Health should actively promote with his cabinet colleagues and their Federal counterparts, the development of clear and comprehensive policies regarding environmental health protection responsibilities.
- present protection activities tend to emphasize the protection of physical health, virtually excludes consideration of mental health.
- only limited, informal recognition given to educational activities; formal recognition given to inspection activities, there is a need to emphasize and expand educational activities.

(3) A comprehensive immunization policy for Ontario should be developed. Consideration needs to be given to what vaccines, to whom, by whom; methods of evaluating immunity levels in the community; supply and distribution of vaccines; costs and methods of public motivation to seek and/or accept immunization and planning for sudden emergency situations.

(4) Expanded or modified policies and programs to support the development of non-institutional treatment services:
(a) the home care program be expanded with greater opportunities for pre- and post-hospital utilization, an increase in the availability of home care and support programs for the chronically ill.

Recommendations cont'd.

(4) - more compatible arrangements must be developed within the home-care program to facilitate its use by physicians and hospitals.
- policies must be developed to prevent misuse of the program as strictly a home-maker service.

(b) the responsibility of individuals or agencies for home treatment and social support, which would allow individuals who require continual assistance to be moved from institutions to the community, must be clarified.
There is a need for the adjustment of policy, program and resource requirements to meet the total range of responsibilities for community living of individuals moving from institutions.
There is also a need to expand experiments in alternative methods of providing primary care, services care.

(5) The public health system be considered to include the Minister of Health, the Community Health Services division, support components from finance, personnel, research and communications areas, Provincial organizations with direct managerial responsibility for public health local official health agencies, district health councils and appropriate voluntary agencies.

(6) The basic goal of the public health system should be the maintenance and improvement of the public's health. The system's primary objectives should be: promotion of factors contributing to health; prevention and control of infectious diseases; and prevention and control of non-infectious diseases.

(7) The responsibilities of all those within the public health system be clarified, modified where necessary, and their proper relationship with one another be delineated.

(8) Local agencies should be encouraged and supported to experiment with alternative forms of management and other efforts to improve human productivity.

(9) Professional expectations of, and basic and continuing educational requirements for, medical officers of health be substantially upgraded.

(10) Provincial/local cost-sharing of services be retained.

(11) The various evaluative techniques currently used in assessing program performance be reviewed in order to ensure that they are appropriate.

(12) Specific evaluative technology relevant to areas of new initiatives and demonstration should be developed.

(13) Ministry should develop greater co-ordination and clarity of purpose of various types of evaluation.

(14) An accreditation procedure for local official health agencies should be initiated.

23. Report of the Health Planning Task Force. Ontario. 1974. (Mustard Report)

combined with

Report, Reaction, Response - The Health Care System in Ontario. Ontario Ministry of Health. 1975.

The 1974 Task Force developed proposals for a comprehensive plan to meet the health needs of the people of Ontario. The Report of the Task Force was published as a Green Paper and considered response was invited. The Task Force made 12 recommendations which were grouped by the Ministry into 6 broad fundamentals.

I. Development of Primary Care

(1) Fundamental - The primary care sector should be developed and strengthened as the front line of an integrated comprehensive health system.
Specific recommendations: (a) provide continuous primary contact service on a 24-hour, 7-day a week basis. The primary care group should be concerned with the continuing well-being of its patients, including prevention, health promotion, health maintenance, consultation, education, diagnosis, treatment and rehabilitation.
(b) Response: Unanimous agreement that continuous care is desirable, but 24-hour availability poses problems. Provision of standby professionals would be too costly. Organization and information arrangements need to be made to ensure that continuous coverage is accessible at all times.

(2) The development of group arrangements that include physicians, nurses and other health professionals working together, providing wide range of services and making maximum use of abilities.
Response: Widely supported, with emphasis on the patient's right to access to the doctor of choice. Variety of group arrangements being tested and studied by Ministry.

(3) Special funding arrangements should be made to promote the development of team approach to primary care.
Response: Experimentation with alternatives to the fee-for-service system was supported, but insistence that this system be retained until alternatives have been thoroughly tested and evaluated. Financial incentives, primarily for development of capital facilities, required to implement the group arrangement suggested.
Ministry supports the development of alternatives to fee-for-service system and is currently testing several. In general, health practitioners provide for their own capital facilities and are reimbursed as they provide services. No change in this system is needed, at this time.

(4) The primary care groups should assume the personal care services of public health that relate to the promotion and maintenance of health.

(4) Response: Rejected by physicians, public health personnel and consumers. Combining treatment and prevention services usually results in decrease in prevention services. Public health personnel could be attached to primary care groups. The Ministry has no plans to relieve public health personnel of their responsibilities for personal care services.

II. Rationalization of Secondary Care

An integrated and co-ordinated secondary care system acting as a resource to primary care is required.
Recommendations: (1) provide consultation and advisory services for the primary care sector. Patients with problems requiring specialized skills and facilities not available in primary care,would enter secondary care by referral from primary care.
Response: Difficult to implement,as it would require a rigid boundary between primary and secondary care. Many services and practitioners provide both primary and secondary care. Important that resources be organized to ensure continuous, co-ordinated services.
Recommendations: (2) organize and rationalize around programs within districts, to promote the effective use of all available services and facilities.
Response: High level of acceptance. Ministry has and will continue to support community initiative in rationalizing secondary care programs, and eliminating unnecessary duplication.

(3) Compensate at specialist rates only for referred specialist services.
Response: Agreement,if the differential in the fee could be billed back to the patient who preferred to go to the specialist directly. Ministry has this area under review. The payment of a premium by the patient is attractive but contains difficulties-i.e. patient's physician may be a specialist functioning as a general practitioner as well.

III. Local Involvement in Health Service Planning

There should be greater involvement in the planning and co-ordination of health services at the local level. Recommendation and responses included:

(1) Set up Health Councils at the district level,to recommend plans for the delivery of health care.
Response: Wide spread support received from the health community and public groups. The Ministry is moving ahead on District Health Councils as fast as local communities want them.

(2) Legislate Health Services Management Boards at area level for management, integration of institutions, administrative support to other programs.

III. Response: A contentious and controversial proposal, which was totally opposed by the general public and almost totally rejected by groups of health professionals. Imposition of such boards by statute would be unproductive and undesirable, in view of complete opposition of the public. The development of local mechanisms by District Health Councils for achieving economics through co-operative activities will be encouraged and supported.

(3) Set up professional advisory committees to DHC at area and district. Response: Concern was expressed for number and layers of committees, and would benefits outweigh costs and time. DHC will be encouraged to develop mechanisms to meet their own particular needs.

IV. Redefinition of responsibility within the Ministry. The Ministry should be restructured to achieve optimal use of DHC's and permit implementation of Task Force proposals for the health system. Specific recommendations and responses were:

(1) Appoint Regional Directors with authority and staff to act for the Ministry.
Response: Perceived by health community as a new layer of bureaucracy. Ministry hasn't created a decentralized regional structure.

(2) Increase province of Research, Information and Communication.
Response: Limited response, but generally in agreement. Creation of new group under Assistant Deputy Minister with responsibility for research development and information systems.

(3) Assume leadership in co-ordinating research programs of the province.
Response: General agreement. Ministry is working out new organizational arrangements and distributions of responsibility in research and development group.

V. Greater Involvement in Manpower Planning and Control.

There is a need for greater public involvement in the planning and control of the distribution of health manpower. Recommendations and responses:

(1) Introduce manpower establishments for various categories of health professionals through DHC. Restrict OHIP registration to those physicians who are approved on the establishment set by DHC's.
Response: Physicians disagreed. Consumer groups objected to human rights implications of such restrictions on practice. Ministry does not feel this action is required at this time.

(2) Steer clinical education programs for improved balance between primary and secondary care, use full range of community facilities and services.

Response: Agreement, but caution expressed regarding adding primary care emphasis to the detriment of strong and successful secondary care clinical experience. Ministry has been working with the 5 health sciences centres to determine appropriate arrangements for clinical teaching in family practice settings.

VI. Improvement in the Delivered Quality of Medical Care

The quality of delivered medical care can be improved through the establishment and operation of evaluation procedures, based on an audit of health services, and a review of the performance of health personnel by their peers in the primary and secondary care sectors, and the development and monitoring of mechanisms to ensure the quality of care within institutions.

Response: General agreement. It would be necessary to implement some of the structural changes in I, II, & III to introduce the improvements in quality of care, envisaged by the Task Force.

24. Report of the Health Planning Task Force. (Mustard Report). Ontario. Ministry of Health. 1974.

Development and implementation of a comprehensive plan for health care would affect health care costs.

Comments relating to Control of Health Care Costs.

A. Financing Health Care Institutions

1. Any health care facility, that receives any portion of its funds from the Provincial Government, for either capital or operating expenses, must be incorporated into the proposed organization for health care services:
   (a) number of available hospital beds should be brought into line with the number determined to be necessary by the D.H.C. within guidelines established by the Ministry;
   (b) appropriate arrangements are required to ensure adequate maintenance and modernization of all hospitals and other health care facilities. Forward planning is necessary to ensure future replacement of the capital plan;
   (c) all institutional facilities, other than public hospitals, must be brought under central planning control and organization of D.H.C. whenever the construction and/or operation of these facilities involves use of Government monies. These facilities must ultimately come under the responsibility of the Area Health Services Management Board.

Long-term savings will be achieved although there will be increased costs over the short term.

B. Remuneration of Health Professionals

A [illegible]. Advisory Committee should be established. Present system of fee-for-service is in need of modification, as it is subject to abuse by some physicians; can militate against the development of a co-ordinated health care delivery system that includes efficient use of allied health personnel; may emphasize curative rather than preventive services, and contains inequitable remuneration of certain categories of physicians. Studies of alternatives that would defer unnecessary use by patients and unnecessary servicing by physicians are required. The alternatives endorsed by the Task Force is a system of unit billing for primary care groups.

The setting of limits on the total expenditures on physicians' services may be necessary, if the Government cannot develop suitable units of service and regulation of manpower.

C. Remuneration for Educational Services

The work of physicians in education should be paid for out of the educational budget. Means of determining the source of costs for education or for service need to be developed.

D. Remuneration of Specialists

1. Differentials in payment based solely on differences in educational qualifications for given techniques or procedures should be eliminated.

2. Primary care provided by specialists should be reimbursed at primary care rates.

3. Specialists should not be reimbursed at specialist rates for services rendered to patients who have not been referred from the primary care sector.

4. The use of hospital facilities by some hospital-based physicians should be studied by the Remuneration Advisory Committee.

5. Suitable mechanisms for monitoring the practices of full-time specialists, particularly the billing for services rendered by residents or interns, need to be established.

6. Placing all hospital-based physicians on salary may be feasible in the future.

E. Financing of Laboratory and Radiology Services

1. Benefits payable to all pathologists and radiologists should be revised, so that payment reflects only the professional component of the service provided.

2. The cost of capital equipment and the operating cost of laboratories should be covered by an alternative method, which is based on the actual cost of providing the service. (Currently obtained through the revenue generated by the fee-for-service schedule).

F. Remuneration of Allied Health Care Personnel

1. Use of unit billing. Unit billing would permit the primary care group to bill for each unit of service included in an approved benefit-for-service schedule, regardless of which health professional or combination of professionals actually performed the service.

2. Enhance emphasis on preventive care, through the development of a type of capitation scheme of funding, or make adjustments in benefit-for-service schedule.

3. Develop a system of peer review and audit of health services to restrict any tendency toward over-servicing.

4. While unit billing system is being developed, provide incentives to primary care groups to use nurses and allied health care personnel. Incentives could be direct reimbursement by the Government of a portion of the salaries of these personnel.

F. <u>Premium System</u>

No longer achieves original purpose of keeping public aware of Health Care Costs.

G. <u>Control of Health Manpower</u>

1. Establish guidelines for determining physician requirements for each district in the Province. OHC to decide on number and type of positions required.

2. Exclude from OHIP physicians who wish to practice in a district that had no opening.

25. Spitzer, W.O., Roberts, R.S., Delmore, Terry.

"Nurse Practitioners in Primary Care: Assessment of Their Deployment with the Utilization and Financial Index". Canadian Medical Association Journal Vol. 114. (June 19, 1976) 1103-1108.

The impact of multi-disciplinary teams that incorporate nurse practitioners on total use of health services was measured with the new Utilization and Financial Index (UF-Index). The key tactic was to convert all categories of health services to a common unit of measurement: dollars expended on health services per person per year. Data from the Burlington randomized controlled trial of the nurse-practitioner and the Smithville-McMaster demonstration project in primary care were used. Findings were:

(a) Burlington household survey data:

The composite UF-Index cost decreased 11%, from $325 to $290 during 1 year. Main sources of the reduction were costs for physician services (32%) and for hospital utilization (31%). There was a 16% increase in costs for the remaining non-hospital categories of service.

Physician-family practice nurse teams can augment primary care resources with much efficiency-e.g. after 2 years, the teams had assumed responsibility for 41% more patients, while increasing the volume of service provided by only 24% and holding the costs to the constant of the Provincial Health Insurance Plan.

The value of the services rendered by each nurse practitioner during the first year was $16,000, of which almost 50% was generated as unsupervised service. Analysis showed that each medical practitioner lost, in net income, $12,000 in the first year. The losses were later adjusted, physicians were reimbursed, from research grant, for any financial disadvantage of the experiment.

(b) Smithville - McMaster data.

Ambulatory, laboratory and radiography costs were excluded, owing to difficulties in data collection. There were substantial increases in costs for all categories of service and in the total cost, that is UF-Index, was $160.54 in 1971 and $247.33 in 1973, a 54% increase. Comparison between the self-selected cohorts of patients of the Smithville-McMaster Family Medical Centre (FMC) and those choosing other practices in the surrounding township (Twp) revealed:

(i) a 36% reduction in use of physician services for Twp. respondents;

(ii) a 47% increase for FMC respondents;

(iii) a 19% increase in the use of nurse practitioners by Twp. patients;

(iv) a 522% increase in the use of nurse practitioners by FMC patients;

(v) a 111% increase in use of hospital services by Twp. patients;

(vi) a 6% reduction in use of hospital services by FMC patients;

(vii) a 60% increase in total use (physician nurse, hospital and other for Twp. patients;

(viii) a 37% increase in total use by FMC patients;

(ix) FMC patients used 19% less in total services than did Twp. patients, dispite a 102% greater use of ambulatory services of physicians and nurses by FMC patients;

(x) Use of the hospital services was 57% less for FMC patients;

(xi) As of 1973, FMC patients used services at $90.12 less per person per year than other residents of the township. Productivity of of FMC: The FMC generated a deficit on service of $44,200. There were 2780 reimbursed episodes of care in the 1st. year of operation, 7700 in the 2nd, and 9725 in the final year of the project. Nonreimbursed care rendered by nurse practitioners in final six months accounted for an estimated 1475 annual visits provided through FMC. Primary care encounters per person in the practice during the final year-averaged 4.9. This figure is somwehat higher than Provincial norm, but consistent with trade-off of more ambulatory care for less hospital care.

Conclusions: Large increases occurred in the use of ambulatory services by practice populations served by physician-nurse practitioner teams, but the ultimate effect has been a substantial reduction in total use of health services. The effect was associated with major reductions in hospital care for the same populations. Rigorous evidence demonstrated no concurrent deterioration in health status of patients or in quality of care.

Although efficient from society's standpoint, this approach is not advantageous for the private family physician or for the University-sponsored teaching unit under current regulatory restrictions regarding payments to doctors and nurses.

26. The Nurse Practitioner in Primary Care. A Report of the Ontario Council of Health. 1975.

The report contains information and recommendations relating to:
(1) definition of the role of the nurse practitioner;
(2) the need for nurse practitioners in Ontario;
(3) the training of nurse practitioners;
(4) methods of remuneration;
(5) regulation and control of practice.

Conclusions

The nurse practitioner in primary care is a co-practitioner, functioning in an expanded role oriented to the provision of primary health care as a member of a team of health professionals and who, through a combination of special education and experience, is qualified to fulfil the expectations of this role (the functions as set out in the Boudreau Report were seen as acceptable and endorsed by Council).

Many services can be adequately and safely provided by nurse practitioners. Support for nurse practitioners is consistent with the principle that every effort should be made to ensure that the various disciplines associated with health services are able to contribute to the maximum of their capabilities. The development of the use of nurse practitioners should not be an "add-on" feature. As nurse practitioners are introduced into primary care arrangement, the impact on the need for other health professionals, particularly physicians, must be assessed. The stressing of ambulatory care and a grouping of health professionals will probably enhance the efforts to constrain the inpatient facilities.

Nurse practitioners have been accepted by public and there is a growing physician interest, but regulatory and remuneration problems need to be resolved. Regulations should be minimal during the developmental phase, and should be flexible to allow the nurse practitioners to assume responsibilities according to her competence and needs of the practice setting. Guidelines, and regulations, if any are necessary, should ensure that public interest is protected, providers are treated equitably and the development of the program is facilitated. The guiding principles for the regulation of health disciples should be applied to the guidelines.

The most practical arrangement for remuneration appears to be on the basis of a salary. Problems with this method arise in practice settings where physicians are remunerated on a fee-for-service basis. A fee-for-service method of paying nurse practitioners is not recommended.

For now, the educational and training programs for nurse practitioners should be placed in the health sciences complexes. Nurses with either a degree or a diploma should be accepted.

Evaluation of the nurse practitioner in primary care, the relevance of the various practice settings and the impact on the health system is basic and essential to the rational development of an efficient, effective and economic health system. A measurable impact on the health system will only be achieved when a considerable number of nurse practitioners have been introduced into private practice and other settings.

A five-year action program should be instituted as soon as possible. Three primary features of the program are:

(1) a number of arrangements designed to encourage the establishment of the nurse practitioner in primary care - e.g. actions to encourage employment opportunities, introduction into situations with clearly established need, evaluation of the social cost and social benefits as integral part of an evaluation program, development of guidelines instead of regulatory arrangements, arrangements for equitable remuneration, public relations program directed toward the general public and the rest of the Ontario health services system.

(2) An expansion of the educational programs to make more nurse practitioners available - e.g. objective to increase the education programs from 75 graduates in 1975 to approximately 250 by 1979. Education program expansion should be geared to ensure that the number engaged as nurse practitioners at the end of the 5 year period is sufficient to have a significant impact on the primary care system.

(3) A major pilot project to include the testing of remuneration methods for nurse practitioners associated with fee-for-service practice. In addition the pilot project will be expected to provide a better perspective on the acceptability of nurse practitioners, the quality of care and the cost effectiveness of the nurse practitioner.

27. Postgraduate Manpower. Council of Ontario. Faculties of Medicine. Committee Report. (Boone Report). Ministry of Health. 1975.

The annual increase in medical manpower in Ontario has exceeded the output of Ontario Medical Schools by 40-50%. Immigrant physicians from outside Canada represent a large proportion of recently registered Ontario manpower. Data on actual manpower base in Ontario are limited and existing controls are unco-ordinated general limitations. Consideration was given to how manpower production of Provincial training programs could maintain relevance to the needs of the Province. Two major possibilities were considered:

(1) Setting an intake quota - this type of control would not be appropriate to programs with a large number of residents due to variation in educational requirements of the students;
(2) Setting an average output quota.

A commitment of a training program to an average output figure was perceived as a more satisfactory means of control. Study groups were formed to make Manpower predictions for Family Practice and the twenty specialities within the Royal College Division, with the exception of Internal Medicine and Laboratory Medicine; and to identify the number of training slots required, and the distribution of training slots by year.

None of the study groups envisaged a significant workload relief by either nurse practitioner or physician assistant. Anaesthesia considered the potential of help from such personnel, but did not foresee it as a major trend (Page 29).

Findings included:

I. Immigration

(a) there will always be a need for a very significant requirement for immigration to replace physicians emigrating; and a
(b) responsibility to train specialists for other Provinces and Nations;
(c) as long as output from the training programs is carefully controlled and regularly reviewed, then danger of over-supply of foreign physicians into Family Medicine and the specialities isn't important;
(d) The present entry mechanism of allowing newly licensed immigrant physicians to enter directly into general practice, upon completion of required internship and attainment of their L.M.C.C. examinations, bypasses the controlling influence of the training program system. Immigration into the field of general practice greatly exceeds predicted requirements;
(e) the immigration of fully trained specialists is necessary in specific specialties;
(f) incompletely-trained specialists are required in most of the training programs - help compensate for Ontario Medical graduates who emigrate;
(g) super-specialists for educational purposes remains an immigration requirement for most specialties.

II. Distribution

Manpower is reasonably well distributed in Ontario in most specialties. The north and northwest areas deficit in Psychiatry and the northeast in Orthopedics. There are distribution disparities in Family Medicine, but no specific undersupplied areas were supplied.

III. On-going Study and Surveillance

On-going study is required and more readily available data is needed-i.e. manpower base, sources of medical manpower and estimation of needs.

Recommendations

A. Training Program Establishments

1. The Council of Ontario Faculties of Medicine set an average yearly manpower output objective for each of the special divisions of medicine sufficient:
   (a) to meet the service, education and research needs of the Province;
   (b) to cover justified training for out-of-Province physicians who will not settle in Ontario.

2. The Council of Ontario Faculties of Medicine recommends for each special division of medicine sufficient training posts to meet the manpower output objectives of the division.

3. The Council of Ontario Faculties of Medicine apportion and assign the training posts to each University.

B. On-going Study and Surveillance

1. The formation of a Central Data Service, which will continually collect and tabulate statistical information necessary to assist each study group to establish and characterize present manpower numbers and future manpower requirements.

2. The permanent establishment of manpower study and surveillance modelled after the present study, with the responsibility for establishing and monitoring on a regular basis. Training program average yearly objectives should be:
   (a) relevant to the manpower needs of the Province;
   (b) appropriately distributed through the Universities.

C. Special Considerations

Four areas were dealt with under this heading. Immigration, academic positions, introduction of new training programs and need for consideration of factors which will influence the quality, availability and distribution of manpower for health care, education and research. Some specific factors requiring in-depth study were identified . . . .

Special Considerations cont'd.

(1) distribution pattern of physicians in each group;
(2) value of designated tertiary centres for very specialized physicians and procedures;
(3) the special needs of certain groups of patients;
(4) the role of the rotating internship in postgraduate training;
(5) Provincial co-ordination and integration of post-graduate training programs; and
(6) ability of the general programs to meet their own manpower output objectives.

28. Report of the Special Study Regarding the Medical Profession in Ontario. (Pickering Report). Ontario Medical Association. April 1973.

The objective of the study was to examine and report on the role of the medical profession and its relations with the public and government in Ontario, the relative economic position which physicians should occupy in society,and method by which modification in physicians' fee schedules, indicated by this study,may best be effected.

Public opinion data were collected on availability of physicians' services; public expectations of physicians; public behaviour in regard to medical services; performance of physicians; the social significance of physicians; physicians' incomes and cost of services; government involvement; future developments in medical services. Data were collected on physicians' attitudes, workstyles, educational background and a variety of other areas such as area of practice, type of practice and cost of providing for retirement.

A. Recommendations (relating to cost containment):

1. (Recommendation #3 of report). The OMA establish a management service in its secretariat.

   Many practicing physicians need expert assistance to improve managerial aspects of practice. Such improvements would lighten the doctor's load and improve service to patients -- i.e. development of efficient answering service, referral lists, rosters for night, weekend and vacation periods.

2. (#4 of report). The OMA to take the initiative with other interested bodies in establishing a medical Manpower Data Unit.

   Some reports indicate that there is an oversupply of physicians in the Province, but the data indicates that physicians aren't available and/or physicians have to work too many hours a week in response to demand. There are indications that about 25% of physicians on the register are not in active practice and the physician-population ratios are of questionable value with respect to service availability.

3. (#5 of the report). The OMAto extend its Joint Procedures for Regular Consultation with the Ontario Hospital Association.

   Hospital administrators complain that physicians are hesitant to exercise control over their peers. A considerable amount of medical practice occurs within the hospital settings which are under pressure to achieve major economics. Close collaboration between the two organizations is necessary.

4. (#6 of the report). The OMA to intensify its consultative procedures with Paramedical Organizations.

   Paramedical groups must be given a wider role in provision of services and free the physician for the more critical and specialized services which he alone can perform. Progress in this area has been slow. Data indicate that the public would welcome greater use of Paramedical services.

5. (#8 of the report). The OMA to reassess its responsibility to the Health Care Delivery System..

Recommendations (relating to cost containment) cont'd.

There is a need to re-examine the practice of medicine in the patient's home - the public is demanding the return of this service; the shift to physician office has resulted in service being available only 25% of the hours in a year and increasing use of hospital services, particularly emergency services.

Medical practice has increasingly become fragmented and there is a need for group or clinic practice.

There is a need for physicians to become more involved in the social, psychological and economic consequences of illness and disability. Consideration needs to be given to rehabilitating and/or maintaining disabled patients at home, through providing necessary care through visits of doctors, nurses etc.

The medical profession should work with other organizations and public authorities to provide the type of services required and to change mode of delivery, if necessary.

6. (#12 of report). The OMA to revise code of Billing Ethics.

   OHIP, at the outset, had few, if any, controls to detect abuse of billing. The Medical Review Committee was set up, at request of OMA , in the College of Physicians and Surgeons to examine alleged abuses. The Fee Schedule contains a statement of the Principles of Ethical Billing, but the emphasis is mainly on procedures and billing ethics in terms of accepted practices within the profession. In view of serious charges of alleged overbilling it would be appropriate to have this statement updated.

7. (#13 of the report). The OMA to urge the Government of Ontario to devise some practicable means of informing the patient of his OHIP billings.

   There are expressed opinions that some patients abuse the system. Patient profiles need to be developed, in order to identify those who exploit the system. The billing system of OHIP provides no information to the patient as to the number and the cost of services claimed. Provision of information to the patient would not only keep patient informed of costs, but also provide a check on physician overbilling.

8. (#14 of the report). The OMA to explore with the Government of Ontario the establishment of a Joint Committee on Doctors' Compensation.

   Revisions in fee schedule need to be made without confrontation and conflict. Data from the public hearings indicated an underlying opinion that the Association should not have exclusive control over its own fee schedule. A joint committee, comprising three representatives each of the Association and Government, would be responsible for reviewing and revising the fee schedule. Its chairman should be a distinguished Canadian recognized for his competence, impartiality and devotion to the public interest.

   There is a need for a major reassessment of the Fee Schedule. Many parts of the Schedule are anachronistic. There are inequities between various specialities.

B. Fee-for-Service

The predominant method of payment for private practice remains the fee system. It is estimated that 25-30% of physicians in private or administrative positions in Ontario, are on salary in whole or in part. This trend will likely continue. Putting physicians on salary would enable physicians to work a reasonable number of hours per week, may be paid overtime for night work, Sundays and holidays and would be entitled to vacation, pension and other fringe benefits. Reliance on salary may reduce motivation to work much longer than workers generally, and hence create a need for more doctors. The total cost of providing physician services would not likely be reduced and probably poorer services would result.

It is preferable to correct the deficiencies in the present fee structure.

29. A Study of the Implications of Using A Plastic Identity Card For the Health Insurance Plan. Management Consulting Division of Government Services. January 24, 1974.

Many service agencies and industrial and commercial enterprises use a plastic identity card. The Ministry of Transport and Communication studied the feasibility of introducing a plastic identity card as a means of reducing high error rate (18%) of driver identication on summons. Only 2% error was due to transcription and transposition errors. Cost of introducing cards deemed not to be justified. Implementation cost of introducing a plastic card with a unique identifier would be same as using a modified OHIP number and the on-going costs would be less. Unable to establish many practical justifications for use of an embossed plastic identity card and not unaware of the intrinsic benefits in public awareness and public relations that would attend the adoption of such a card.

Recommendation: (1) A decision on the question of adopting an embossed plastic identity card for OHIP be delayed until such time as the issue of a unique personal identifier has been resolved.

(2) When OHIP adopts a unique permanent personal identifier, an embossed plastic card be introduced as the vehicle for bearing this information for each participant.

30. <u>A Study of the Implications of Using a Personal Identifier in the Ministry of Health.</u> Management Consulting Services Division. January 22, 1974.

Data for research, planning and control needs to be made easily and economically available. The cost of consistent and complete information to meet the requirements of social /welfare and medical programmes will be prohibitive, if no form of standardized unique personal identification is produced now. Several Provinces are already using the Social Insurance Number (SIN) for this purpose. Present identification system used in OHIP has severe limitations.

The expense justification includes:

(1) Allow generation of more complete profiles on doctors and patients, to monitor doctor and patient abuse;

(2) Ability to calculate accurately doctor/patient ratios, growth and declining areas of health requirements;

(3) Improvements in health care delivery - Individual Health file would permit researchers to assess long-term benefits of harmful or different treatment methods; identification and follow-up of high-risk groups for purposes of preventive medicine; identify causes of disease.

(4) Improved data handling in OHIP.

<u>Costs</u>	Implementation	$5,343,000.00
	Annual Costs - Increase in OHIP Complement and processing costs	$2,000,000.00

Recommendations

1. The Ministry of Health adopt a unique personal identifier for use in all its people-oriented programmes, including the OHIP. The unique identifier should consist, in whole, or in part, of an uniquely assigned code or number for each individual, and further, should incorporate a check-digit of adequate discriminations.

2. The Administrative aspects of the issuance and control of the identifier be governed through a centralized agency or organization.

3. Ministry of Health adopt and standardize the use of the Social Insurance Number as a unique personal identifier for all its people-oriented programmes, including OHIP.

4. Legislation be introduced to make it mandatory for each Ontario resident to possess a SIN.

5. The Federal Government be approached with a view to establishing a separate agency for the administration of SIN as a national personal identifier.

   (Control over all aspects of data gathering use and dissemination be in one central agency.)

6. The Ontario Statistic Board act as the central controlling agency responsible for establishing standards for the gathering, use and dissimination of all data within the Ontario Government.

   (i) Define the extent and limits of interfaces that that will be permitted to exist between bodies of data gathered for different purposes - particularly between social/welfare and justice-oriented data.

   (ii) Establish guidelines for proposed legislation to control the gathering, accessibility, use and retention of personal data.

7. Ontario Statistics Board actively promote the universal adoption of the Social Insurance Number as a unique personal identifier for all current and new Social Policy Field programmes in the Ontario Government.

31. Report on the Evaluation of Chronic Home Care. Ontario Ministry of Health. 1977

In 1975, the existing Home Care programs in Kingston, Thunder Bay and Hamilton were extended to include Chronic Home Care. Acute Home Care was extended in each of the 38 programs to include Institutional Home Care (IHC).

Evaluation of Chronic Home Care was to be conducted prior to further expansion.

Findings and Conclusions

(1) Acute Home Care (AHC) Program

This program serves a wide range of patients who are usually diagnosed for post-surgery or accidents and poisoning, who stay 26 days, usually to be discharged to the community, at a fairly steady level of service demand, of a service cost of $4.57 per day.

(11) Chronic Home Care (CHC) Program

The program serves a more elderly patient with a diagnosis of circulatory or "other", who receive similar proportions of services as the AHC patients, at a cost of $3.92 per day, stay for 57 days for a greater cost per case and are discharged as often to a hospital as to the community. Level of service on the CHC program was still increasing rapidly as of March 1976.

Chronic Home Care is a cheaper service than any type of hospitalization. The admission - discharge flow data gives evidence that the program is meeting its objectives of easing or preventing deterioration, and therefore transfer to institutions giving higher levels of care. CHC clearly serves the older population. The anticipated increase in this segment of the population warrants serious consideration of expanding CHC as a major health care service for those individuals.

Recommendations

1. That the Chronic Home Care Programme continue for another 18 months as it presently exists in Hamilton, Kingston and Thunder Bay.

2. That the more extensive evaluation now feasible, due to stabilizing case load, be carried out on the Chronic Care Programme for a 12-month period (allowing 4 months to prepare for the study and 2 months to prepare the report).

3. That the Home Care Information System be revised to provide specific data and indicators of health status.

32. <u>Science for Health Services</u>. <u>Science Council of Canada.</u> Report No. 22. October. 1974.

This report emphasizes the re-structuring of the health care system to match the system to the needs of the individual, rather than force the individual to match the system. The re-organization of health care in Canada into an integrated system is perceived as a means of achieving reduction in the rate of cost escalation. Improved efficiency should result in the provision of more service per dollar, but total operating costs may increase. Waste needs to be eliminated. Additional costs are justified for the achievement of the objective of making good health care available to all who require it. Limits need to be set on financial resources available for health care system. Recommendations include: 1. Re-organization of the system from practitioner to governmental level; 2. redefinition of roles of personnel to reduce restrictions on services that can be performed by various personnel; 3. enhanced protection of health - long-term planning and determined policy-making required, allocation of funds for health promotion programs, increased emphasis on health protection with priority given to the protection of children, and expansion of roles and responsibilities of public health personnel; 4. establishing priorities for research and development - identification and use of health indicators, development of computer - based health information system, standardized health records and linkage of birth, ambulatory care, hospitalization and death records on a national basis; 5. determination of effectiveness of approaches to health protection, and knowledge required for accident prevention and safety education programs; and 6. organization and funding of research and development in health field.

33. Health Care in Canada. A Commentary. Background Study for the Science Council of Canada. Special Study No. 29. August 1973. (R. Robertson Report).

This study examines the overall level, adequacy, and appropriateness of research related to the development of a comprehensive and co-ordinated system of health care. Findings included: marked deficiencies in the data base required for proper planning and assessment of results, and research needed to identify and develop methods of obtaining data required; ways of measuring quality of health care are incomplete and inadequate. Co-ordination and refinement of present methods and development of better methods are required. There are problems in the delivery system and research is required to develop ways of determining how the system is working. Changes in roles of some practitioners may serve to overcome some of the deficiencies in the system - e.g. greater use of nurse practitioners. Manpower requirements are difficult to predict due to lack of information on the present situation. There is a need for continued Federal involvement in Health Sciences Research Funding and in the maintenance of uniform standards for each profession and technology. Provision of co-ordinated diagnostic ambulatory and continuing care facilities are needed to relieve hospital overloading. Regionalization of specialty services is required. Regionalization of health care services should be implemented gradually. There is room for improvement in efficiency of delivery. The amount that should be spent on health care is unknown. The use of computers in the health field is limited. Research is required to find better educational matters with respect to health protection. Research support should come mainly from Federal sources, the development of a research field should be carried out by a non-political body dedicated to research, and government departments require the means of supporting relevant research.

34. Regional Organization of Health Services. Report of the Ontario Council of Health. Supplement No. 1, 1970.

The 12 recommendations contained in this report relate to the establishment of regional and district health councils, their boundaries, composition, functions, relationship between regional and district councils and the role of the Provincial Government in the establishment of regional and district health councils. Every proposal for new health facilities and services, modifications of existing facilities and additions to existing facilities, requiring capital or operating funds from the Province be routed through district and regional health councils for approval or otherwise. (Recommendation #1).

This action is necessary to the survival of regionalization of health services. The regional councils have the overall responsibility of providing, through co-operation and planning, the best possible health services for the residents within the region. The elimination of duplication, effective balance and distribution of basic and specialized services, and effectiveness and ease of delivery of services need to be ensured. The definition of requirements, the preparation of an inventory of existing services, the assessment of existing services and the development of programs to ensure the most effective use of professional and technical personnel, and the most efficient use of financial resources available are responsibilities of regional councils.

The district health councils have responsibility for providing: assistance and advice for its own district to the appropriate regional council on the organization and development of co-ordinated health services within the district; integration of health services within the district; and ensuring that recipients of health care have maximum access to those responsible for providing services.

The authority of regional and district councils needs to be established by legislation, and the Province needs to establish policies, standards and guidelines to provide the framework within which the councils will function (Recommendation #2).

35. A New Perspective on the Health of Canadians (Lalonde Report). Department of National Health and Welfare, Government of Canada. 1974.

This report contains a discussion of the limitations of the traditional view of the health field— i.e. emphasis on and priority in financial resources allocation given to the medical care system; the role of human biology, environment and life styles in sickness and death of Canadians; the institutional powers and role of the Federal Government in the health field; proposes a conceptual framework for studying the health field; illustrates the use of this health field concept in the analysis of health issues and policy development; and formulates two broad objectives, five main strategies and seventy-four possible courses of action.

The Health Field Concept divides the health care field into four elements:

(1) Human Biology - all aspects of health, both physican and mental, which are developed when the human body as a consequence of the basic biology of man and the organic make-up of the individual— e.g. genetic disorders.

(2) Environment - all matters which are related to health which are external to the human body and over which the individual has little or no control e.g. air pollution.

(3) Life style - aggregation of decisions by individuals which affect their health and over which they more or less have control- e.g. smoking.

(4) Health Care Organization - the quantity, quality, arrangement, nature and relationships of people and resources in the provision of health care.

The main causes of sickness and death in Canada are based in the first three elements and more attention must be given to them. Improvements in the environment, changes in life styles and greater understanding of biological factors are sources of potential savings in costs of providing curative services.

Some of the major problems in the organization and delivery of health care arises from conflicting goals or principles-e.g.:

(1) equal accessibility to physician services versus permitting physicians to choose area of practice.

(2) control of costs versus ready access to services for all, resulting in removal of incentives to patients, physicians and hospitals to control costs.

(3) provision of a balanced supply of various medical specialties versus permitting physicians to select their field of specialty.

(4) provision of services by staff trained only to the level of skill required for task performance versus licensing patterns and fee-for-service systems, resulting in some health professionals performing tasks that could be done by others as well or better, and often at a lower cost.

(5) value of research and prevention recognized and greater financial resources given to treating existing illness.

Proposed health-promoting strategies are directed at informing, influencing and assisting both individuals and organizations to accept more responsibility and be more active in matters affecting mental and physical health.

The proposed regulatory strategies are aimed at reduction of hazards to mental and physical health-e.g. promoting use of seat-belts.

The research strategy is designed to help discover and apply knowledge need to solve mental and physical health problems.

The goal-setting strategy will establish, in co-operation with others, specific, time-limited goals, stated in quantitative terms, for raising the level of the mental and physical health of Canadians and improving the efficiency of the system.

The objective of the Health Care Efficiency Strategy is to help the Provinces reorganize the system for delivering mental and physical health care, so that cost, accessibility and effectiveness are balanced in the interests of Canadians.

Actions proposed under this strategy include:

(1) method of financing that will provide incentives for providing satisfactory care at the lowest cost, and permit extension of pre-paid care to additional essential services;

(2) the support of home visits and other programs for helping chronically ill and aged people to stay in their communities;

(3) the continued extension of the role of nurses and nurse practitioners in the care of the mentally ill, in the care of the chronically ill, in the provision of home care, in family counselling on preventive health measures, both mental and physical, and in the abatement of environmental hazards and self-imposed risks;

(4) the organization and administration of an improved drug information system to physicians, so that they will make a more effective and objective use of drugs;

(5) the encouragement of the development of regional bodies with comprehensive authority over the delivery of health care in their respective regions.

36. Report of the Task Force on District Health Councils. Ontario Council of Health. 1975.

The Task Force reviewed the current guidelines, status and functioning for planned and existing district health councils in Ontario, and proposed guidelines consisting of the available options with their pros and cons for the establishment, functional organization and administration of district health councils.

The Task Force recommended the encouragement of district health councils for decentralized community-oriented health planning. The remaining twenty-five recommendations related to establishment of Councils, composition of council membership; establishment of district boundaries, relationships among district health councils; liaison with social service; relationships with health sciences centres; responsibilities of district health councils with respect to manpower planning, co-ordination of programs, program implementation, integration of health services, operation of services, control of funding; Provincial level co-ordination; liability of council and Committee Members and health councils in Metropolitan Areas.

District Health Councils permit planning for the most satisfactory services of a reasonable cost. Recommendations relating to cost containment include:

1. (#18 of Report)
   DHC, individually or jointly, be involved in the planning of health manpower needs. They should also be consulted by Health Sciences Complexes regarding health manpower needs.

2. (#19 of the Report)
   That as an incentive, part or all savings that arise from co-ordinated programs be available to the district health council to initiate new or expanded services.

3. (#21 of Report)
   That special purpose health institutions (e.g. cancer, and alcohol and drug addiction) gradually attain the same relationship to district health councils as other providers of health care.
   (DHC should recommend or suggest needed services as they perceive them, but the over-all distribution of such services throughout the Province, as well as research and education associated with them, should be decided in co-operation with all DHC's).

4. (#23 of Report)
   That DHCs not assume direct responsibility for day-to-day operation of services, but that they retain responsibility for the planning and over-all administration of services.

5. (#24 of Report)
   That complete information regarding all expenditures for health in districts - and estimates of available resources be provided to district health councils, and that the Ministry of Health not make decisions regarding allocation of funds without the advice of the district health council.

37. Health Research Requirements. Task Force Report. Ontario.

The 48 recommendations presented deal with the role of Federal resources in funding research of national interest; defining the Provincial role in health research; amount of funds allocated to health research (private and public funds should amount to 4.5% of the total expenditures on health care); increased funding be directed almost equally toward level of service and cost reduction research and applied and developmental research; resources be made available for education and training of needed health research manpower; specific long-range objectives for health research in the Province be adopted - e.g. avoidance of duplication of facilities, balance between upgrading present or provision of new facilities, maximum use of human and physical research resources, achievement of appropriate mix of research, etc.; adoption of specific short-term objectives relating to resource allocation and co-ordination of research; establishment of a standardized data base; rigor and central control of data on health research resources; specific recommendations relating to the five health sciences centres, expansion of dental research, provision of financial support for preparation of nurses as researchers and increase funding to University schools of Nursing to achieve appropriate mix of research and training; and increased funding for support of methodological resources.

38. Report of the Provincial-Municipal Grants Reform Committee. Vol. I. Chapters 7 and 8. Ontario 1977.

Co-ordination of the components of the health system may best be achieved through centralizing the responsibility for financing and policy development of health care, while retaining a decentralized administrative apparatus at the local level.

Recommendations are made to have the Province pay the full costs of financing health services administered by local governments, subject to approved annual levels of expenditure based on Provincial standards; to decentralize the responsibility for community-oriented health services once a co-ordinated system is achieved; to eliminate Boards of Health as special bodies and have this function become a direct responsibility of upper-tier councils; that health-oriented services under the homemakers' and nurses' services programs be consolidated into Ministry of Health's Home Care Program.

There are a number of funding anomalies associated with the provision of residential services to the aged. A recommendation is made that the Province re-examine its structural and funding approach with respect to all residential care for the aged, with a view to consistency with related programs. Attention needs to be given to the appropriateness of the municipal role in providing extended care.

39. <u>Mental Health Services Personnel</u>. A Report of the Ontario Council of Health. 1973.

Improvement in mental health services is seen as a result of bringing together the many workers in the mental health field into a single structure, with common standards of competency that are recognized and certifiable. Clearly defining functions, and providing certification for those who demonstrate competence in performing these functions, is the means of regulating practice.

Recommendations related to the establishment of a College of Mental Health Practitioners; the functions of the College; clear definition of functions in the mental health field, and classification and certification of workers; according to level of competence, and discussion of the report and its recommendations by various occupational and professional groups.

40. <u>The Planning Function of District Health Councils.</u> Ontario Council of Health. 1977.

The Report of the Task Force on the Planning Function of District Health Councils 1977,and A Framework for the Development of a Data Base for District Health Councils November 1976, are the source documents for this report.

The report provides a summary of the planning function. The report discusses the distinction between short term problem-solving and comprehensive long term planning; the need for operational, comprehensive and strategic planning; criteria for identifying needs and the significance of a sound data base; priorities and options, the implications of cyclical planning, levels of quality and service; and the importance of providing members of DHC's with facts, figures and briefings.

Stress is placed on the establishment of a necessary network of relationships inside the health care system-structure of councils, health professionals, health agencies, health sciences centres, Ministry of Health, other district health councils; outside the health care system - health related agencies, community involvement, and inter-ministry co-ordination; and the need for adequate resources - data base, manpower, health sciences and finances.

41. Evaluation of Primary Health Care Services. A Report of the Ontario Council of Health. 1976. (Spitzer Report).

This report presents a methodological strategy for judging the performance and acceptability of primary care services.

Five indicators of performance of primary care units (PCU's) were identified. These are:
(1) Utilization of health services and financial performance;
(2) Accessibility, availability and scope of service;
(3) Quality of care;
(4) Consumer satisfaction;
(5) Satisfaction of health professionals.

The first three indicators are the essential measures of performance and quantitative Indexes for each were developed. Methods for measuring the remaining two indicators were developed and described.

The evaluation plan proposes the derivation of index scores for the indicators of performance in a representative sample of normative practices in Ontario, for all residents in delineated geographic areas and for the Province as a whole. These index scores would serve as reference scores for scores obtained for new alternatives or practices such as Health Services Organization (HSO's) and Underserviced Area Practices (UAP's).

A control panel of 320 practices of the Province, comprised of several sub-panels with distinctive characteristics, would be assembled through probability sampling. This control panel would provide Ministry with a periodic "Dow-Jones" of costs of health services.

Minimum eligibility criteria for HSO's and UAP's have been delineated. Desirable characteristics for such units and common alternatives of consumer and provider sponsorship of HSO's and UAP's were described.

A proposed sample size of 50 HSO's was considered to be the minimum acceptable in order to perform meaningful evaluation of the several sub-categories of HSO's.

An information system, which will permit acquisition of all the data needed for evaluation purposes, was described and recommended.

Detailed description of all components of the evaluation plan is provided. In essence, the plan provides for the evaluation of normative practice unit (NPU's) and HSO's and UAP's and permits comparison of the various alternative arrangements in the provision of primary care.

Normative practice unit is defined as an individual or group of health professionals, providing primary care services reimbursed on a fee-for-service basis according to current regulations and prevailing patterns of financial arrangements, and whose relationship with government is not mediated by the Project Development and Implementation Group (PDIG). PDIG has responsibility for the development and implementation of health service organizations (HSO's) and underserviced area practices (UAP's).

Health services organization(s) (HSO) is defined as an organization or community representatives and/or a group of health professionals who have contracted with PDIG to provide primary care and/or speciality services and meet eligibility criteria for such organizations.

Underserviced Area Practice(s) (UAP) are primary care units located in areas of the Province which are designated underserviced with respect to health professionals, which meet eligibility criteria and which are eligible for funding through the Ministry of Health's Underserviced Area Program.

Recommendations

(I) Measures should be taken to ensure stability and continuity of the Project Development and Implementation Group (PDIG) during the 4 years of the evaluation of the program.

(II) An ongoing Evaluation: Implementation and Review Committee with a majority of members who are professionals be established, to serve as an ongoing monitoring and advisory committee to the Minister on matters pertaining to primary care units (PCU) under special funding arrangements.
A Clinical Peer Review Sub-committee of clinicians be established under the jurisdiction of the main committee to advise it, and through it, advise the Minister on all aspects of evaluation which requires clinical judgment.

(III) An independent Evaluation Unit responsible for developing and implementing the evaluation methods proposed in this Report, should be established directly under the Assistant Deputy Minister for Community Health Services and accountable methodologically to the Evaluation, Inplementation and Review Committee.

(IV) The strategy described in detail comprises a complex and interlocking series of components which are a unitary whole.

42. <u>Report of the Royal Commission on Metropolitan Toronto</u> (Robarts Report) Vol. 1-2. 1977. Province of Ontario (TEIGA).

Two areas were addressed by this Commission:

(1) an assessment of the organizational responsibility for the provision of public health services; and

(2) examination of the role, if any, of the Metro system of government in helping to plan, co-ordinate and control the delivery and financing of the broader range of publicly-financed health services in the Metro area.

<u>Recommendations</u>:

(1) Public Health remain a responsibility of the area municipal level in Metropolitan Toronto.
- creation of a single district health unit to serve more than 2 million persons would not likely lead to economies or improvement in services. The 6 health departments currently provide a high level of service and are responsible to particular needs of local communities.

(2) The Metro Council be given a limited, co-ordinating and non-operational role in public health, and be authorized to provide central statistical or other analytical services at the request of the area municipal level.
- scope of public health function will widen. Mechanism needed to enable municipal units to work together.

(3) Public health expenditures in Metro be eligible for Provincial grant support, at a rate equivalent to that given to district health units.
- the six area municipal boards of health are subsidized at the rate of 25% by Province, 75% subsidy being withheld until such time as the boards are amalgamated. There is no good reason to justify the differential in Provincial subsidization.

(4) The responsibility for public health under the Public Health Act and other Provincial statutes be transferred to the area municipal councils of Metropolitan Toronto.
- proper for public health services to be operated directly by the area municipalities; interdependency of public health with other municipal responsibilities is now recognized.

(5) The Metropolitan Council be designated as the District Health Council for Metropolitan Toronto; - Metro Council directly responsible to electorate for developing and implementing a human service policy for Metro; - Metro Council currently supplies capital grants to hospitals; - ready-made, publicly accountable and highly flexible vehicle to achieve Provincial health objectives in Metro.

43. Health Research Priorities for Ontario. A Report of the Ontario Council of Health. 1977.

This report deals with establishing priorities for health research within the context of goals and methods of the health research community, and society's expectations of the impact of health research on health care.

Recommendations focus on re-affirmation of the Province's responsibility to maintain a balanced and long-term research program; the use of estimates of economic burden of ill-health in determining priorities for resource allocation among disease categories; knowledge and opportunity as determinants of priorities within disease categories; high priority to be given to fields of virology, genetics, immunology and cell biology; research fields inadequately funded and requiring high priority - environmental and occupational health, nutrition, toxicology and epidemiology; development of health-related record linkages; support for personnel; and the use of contract research.

44. An Estimate of the Economic Burden of Ill-health. A Study for the Ontario Council of Health. 1976.

Estimates of the over-all burden of ill-health were based on direct and indirect costs. Direct costs considered were: personal health care - hospital costs, non-hospital medical care costs and other costs; non-personal, public health care costs; education; and research. Indirect costs were: monetary - mortality, morbidity - treated (institutional), untreated; - and non-monetary (pain, sorrow etc.)

Estimates of direct burden, indirect burden and total economic burden of 18 major diagnostic categories of ill-health (Categories are those of the ICDA - 8th Revision for Ontario), are presented. Suggestions are given regarding potential use of estimates for determining priorities in health research. Economic criterion, that is, social benefits outweigh social costs, needs to be applied to health research. The estimates of economic burden are a means of calculating social costs.

Paucity of, and deficits in, data base were recognized in the development of estimates. Circulatory, accidents, mental and digestive categories occupied the first four positions in the rank-ordering of disease categories according to estimated total burden of ill-health in Ontario in 1971.

45. <u>The Economics of Health Research. Ontario Council of Health. 1973.</u>

This report does not deal with health care cost containment or financing. The report focuses on the role of Government and public financing of health research; the need for an economic classification of research, that is, research directed toward discovering of new information (Type I); on the availability and use of health care or level of service (Type IIA), and on the efficiency of the system by which it is provided, or cost-reduction research (Type IIB); the need for increases in research funds from public financing; the distribution of funds-e.g. Type IIA and Type IIB research needs to be given priority (An economic classification of research rests on the criterion that all research activities in which the social benefits are greater than social costs should be supported); the role of institutions in funding, and performance of health research, allocative criteria for research; and allocation of resources within the health research sector.

45. The Economics of Health Research, Ontario Council of Health, 1971.

This report does not deal with health care cost containment or planning. The report focuses on the role of government and public financing of health research. The need for an economic classification of research, (p. 7), research directed toward the generation of new information, (pp. 11) on the desirability and use of health care [illegible] level of service (page 118), and on the [illegible] of the system by which it is provided [illegible] for increases in research funds from public financing, the distribution of funds [illegible] (pp. 126 and 170) research needs to be given priority. [illegible] criteria that the research [illegible] are greater [illegible] suggested. The role of institutions in funding and performance of health research. Alternative methods for research. The allocation of resources within the health research sector.

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